Complete Evaluation / INPATIENT: Eating Disorder Center
Liz Lobao LCSW

Smith, Stacey

ID: 1000010651905 DOB: 9-5-1998

HISTORY: Stacey is a single, American 15 year old young woman. Her chief complaint is, "My parents are over involved in my eating habits."
The following information was received from:
Stacey.
Family: both parents
A professional source: gynecologist

Symptoms of anorexia, with a refusal to maintain a normal weight, are present. Stacey refuses to maintain a normal body weight. She expresses a fear of gaining weight. She denies the seriousness of her medical condition. Her self image is unduly influenced by her body size and shape. No purging, inappropriate use of laxatives, diuretics, enemas or pills are reported.
Stacey frequently checks her weight. This typically occurs three times a day. Stacey carefully scrutinizes her body for signs of what she considers excess weight.

Stacey follows the following dietary restrictions: She carefully counts calories. She consumes less than 1000 calories a day. Dietary fats are scrupulously avoided. Fluids intake is restricted. Stacey exercises excessively as a weight control technique. She exercises three or more hours a day

.
Nutritional History :
Measurements:
Height = 5' 5" (165 cm)
Weight = 100 lbs. (45.4 Kg)
BMI = 16.6, considered Underweight
Ideal Weight Range = 118-131
% Ideal Weight = 80

Current Dietary Orders / Meal Plan:

Gentle Diet
Add 200 300 400 kcal snack for total of kcal / day.
Add Benecal to 10 AM 3 PM 8 PM Scandishake snack for a total of kcal / day. Change 10 AM 3 PM 8 PM snack to 200 300 400 kcal snack for a total of kcal / day.

Nutritional History: There is no apparent precipitant for the onset of Stacey's eating disorder. The eating disorder, the age at which eating and weight took on a special significance, began around age 12. The course of this eating disorder has been basically chronic and unremitting. Stacey's adult weight has been in the following range:

High weight: 125-130
High weight occurred at age 13.
Low weight: 90-95
Low weight occurred at age 15
Current weight: 100 lbs.
Recent Weight Loss: Stacey has recently lost 1-3 pounds. This weight loss has occurred over the past month.

Current Height: 5'5"
Prior In Patient Treatment: Stacey has never received out patient treatment for her eating disorder.
Prior Out Patient Treatment: Stacey has never received out patient treatment for her eating disorder.
Prior Dietitian Experience: Stacey has been advised by a dietitian. Details are as follows: Stacey was noncompliant with scheduled appointments.
Current Self Perception: Stacey sees self as of normal weight.
Attitude/Experiences: She describes her family attitude towards her weight and eating habits as follows: "They monitor every single bite I put into my mouth, it is frustrating. "Stacey denies using food to avoid or suppress feelings. Stacey describes the following effect of her occupation or recreational activities on her eating habits: "Dance and exercise are my life, I have to be trim in order to perform."
Stacey's motivation for change is described as poor.

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PAST PSYCHIATRIC HISTORY:

Prior Care Setting: Stacey is new to mental health treatment and does not have a prior care setting.

Prior Psychiatric Disorder: There is no prior history of a psychiatric disorder.

Psychiatric Hospitalization: Stacey has never been psychiatrically hospitalized.

Suicidal / Self Injurious: Stacey has no history of suicidal or self injurious behavior.

Addiction / Use History: Stacey denies any history of substance abuse.

Medication Compliance: There is no history of medication non compliance.

Psychotropic Medication History: Psychotropic medications have never been prescribed for Stacey.

Past psychiatric history is otherwise entirely negative.

SOCIAL/DEVELOPMENTAL HISTORY:

Developmental History: There were no post-partum complications. Birth weight was 8 pounds 4 ounces. Stacey passed the various developmental milestones at age appropriate times.

High Risk Psycho-Social Issues:

Family Negativity: Stacey's family is negative about or uncooperative with mental health services. It is felt that the risk of treatment non compliance by Stacey is increased because of her family's negative attitude toward mental health services.

Childhood History: Stacey was born in NYC. Stacey was raised by her parents, as part of an intact family.

She is the oldest child of four.

Family Stressors: Stresses on family life have included the following:

Financial Problems

Legal Problems

Current stress level on this family is considered high.

Childhood was dysfunctional and non supportive.

Indicators of emotional problems include the following;

Eating Disturbance;

Defiant or Oppositional Behavior

Violation of Rules

School History:

Stacey is currently in tenth grade. She was retained in third grade.

Current School Behavior: She Has a best friend. She takes responsibility for her behavior.

Stacey is interested in further education and a career. She has had few if any disciplinary problems. Stacey gets along well with adults and authority figures. Stacey gets along well with peers.

Abuse / Protective Services:

There is no known history of physical or sexual abuse or emotional abuse.

Financial Status: Stacey is financially comfortable.

Residence Status: She lives with her parents.

Support System: Stacey has the social support of the following:

On line or Internet friends: This person or group provides only limited support.

Substance Abuse: Stacey has the following history of substance abuse. Stacey denies any history of substance abuse.

Strengths/Assets: Stacey is intelligent. She is verbal. Stacey is a good student. Stacey has good artistic skills. Stacey has good communicative skills. She is able to express feelings. She is financially secure.

Barriers to Treatment: Lack of motivation for treatment is a barrier and an obstacle to progress: Therapy will focus on motivational problems first.

Patient's Goals: "I want to go home."

Stacey was the product of a full term and uncomplicated pregnancy, labor and delivery.

FAMILY HISTORY:

Sister thought to have an eating disorder.

Cousin hospitalized for an eating disorder.

This family member is maternally related.

There is a significant family history in first and second degree relatives of the following: Family history is positive for psychiatric hospitalization. This is reported in the maternal side of the family.

Current Family Stressed include the following:

Relationship Problems with both parents over diet and exercise issues and her current lifestyle.

There is no history of any of Stacey's close family members having been abused.

MEDICAL HISTORY:

Adverse Drug Reactions: List of Adverse Drug Reactions:

(1) Added ADR to Ampicillin, Reaction(s) = Bronchospasm, Status = Active

Allergies :

Peanuts (Hives) (Dyspnea)

Current Medical Diagnoses:

None

Current Medications (non psychotropics) include: None

Past ***MEDICAL HISTORY:***

Past Medical History is essentially negative. Stacey reports immunizations are current.

Pain:

Stacey describes current pain. She describes pain in her lower back. The pain is of moderate intensity. It cannot be ignored and interferes with concentration.

(no pain)----------l----------(unbearable)

The pain occurs after exertion. The pain is described as burning. It occurs several times a day. When pain occurs it lasts for hours. Certain movements or positions worsen the pain when she dances. Stacey reports that physical therapy has helped relieve her pain. Stacey reports that a TENS unit helped with her pain. Current pain is felt to be under adequate control.

Stacey was asked to rate her pain on a scale of 0-10 where 0 is no pain and 10 is the worst pain imaginable. Current pain is rated as 5.

Cardiac: There is no family history of early death due to cardiac arrhythmia or conduction defect or other related cardiac issues.

Medical history is otherwise negative and Stacey has no other history of serious illness, injury, operation, or hospitalization. She does not have a history of asthma, seizure disorder, head injury, concussion or heart problems. No medications are currently taken.

MENTAL STATUS: Stacey presents as glum, listless, inattentive, well groomed, and slow to respond. normal in rate, volume, and articulation and is spontaneous. Language skills were not formally tested. Signs of moderate depression are present. She appears listless and anergic. Slowness of physical movement helps reveal depressed mood. Facial expression and general demeanor reveal depressed mood. She denies having suicidal ideas. Her affect is congruent with mood. There are no apparent signs of hallucinations, delusions, bizarre behaviors, or other indicators of psychotic process. Associations are intact, thinking is logical, and thought content appears appropriate. Cognitive functioning and fund of knowledge is intact and age appropriate. Short and long term memory are intact, as is ability to abstract and do arithmetic calculations. This patient is fully oriented. Clinically, IQ appears to be in the above average range. Insight into problems appears to be poor. Social judgment appears to be poor. There are no signs of anxiety. There are no signs of hyperactive or attentional difficulties. Stacey displayed defiant behavior during the examination. Stacey displayed uncooperative behavior during the examination. Stacey made poor eye contact during the examination. No signs of withdrawal or intoxication are in evidence.

DIAGNOSES: The following Diagnoses are based on currently available information and may change as additional information becomes available.

Axis I: **Anorexia Nervosa Restricting Type, 307.1 (F50.01) (Active)**
Axis II: Deferred Diagnosis 799.99
Axis III: See Medical History
Axis IV: Primary Support Group
Social Environment
Axis V: 60

CLINICAL SUMMARY:

RISK ASSESSMENT: SUICIDE/VIOLENCE

History of Risk Factors:

Stacey has a history of self injurious behavior. She has cut herself.

A family member has a history of suicidal behavior. A family member has committed suicide.

Current Risk Factors:

A major depression is present.

Serious current medical problems are present related to her belief that she is overweight.

Protective Factors:

Strong Therapeutic Relationship

Suicide Risk:

Based on the above risk factors the risk of SUICIDE is considered MEDIUM.

Violence Risk:

Based on the risk factors reviewed the current risk of VIOLENCE is considered VERY LOW or absent.

INSTRUCTIONS / RECOMMENDATIONS / PLAN:

Psychiatric Hospitalization is recommended because this patient's condition requires 24 hour monitoring due to potential danger to self or others or severe deterioration of level of functioning or need for medically monitored detoxification, and less intensive treatment has failed or is likely to fail.

Behavioral Therapy:

Cognitive Therapy:
Encourage all activities:
Unit Meetings:
Family Therapy:

Start Prozac 20 mg PO QAM (Depression)
Start Abilify 5 mg PO QAM (Antidepr Augm.)
Start Ambien CR 6.25 mg PO QHS PRN (Insomnia)

NOTES & RISK FACTORS:
History of cutting wrists when profoundly depressed.

90791 Integrated Bio-Psychosocial Initial Assessment

Time spent face to face with patient and/or family and coordination of care: 45 minutes

Session start: 09:00
Session end: 09:45

Elizabeth Lobao LCSW

Electronically Signed
By: Elizabeth Lobao LCSW
On: 10/30/2013 1:49:30 PM