INTENSIVE OUTPATIENT SETTING
2121 Main Street
Anywhere, USA

**Bio-Psychosocial Assessment**

Date of Exam: 7/1/2015
Time of Exam: 1:31:51 PM

Patient Name: Smith, Jenny
Patient Number: 1000010660043

History: Jenny is a married Canadian 37 year old woman. Her chief complaint is, "I am tempted to drink?"

Information Received From:
Jenny

Drug Used:
Alcohol: The following are described:
*Craving, or strong desire or urge to use alcohol.
*Important social, occupational, or recreational activities are given up or reduced because of alcohol use.

Length of Use:
Since Age: 24.

Precipitating Events:
*Previous strong association with substance use occurred.
*Strong reminder of the good times when using substance.

Last Used:
Days Ago:
*Uses for Self Confidence

Amount Used:
*Uses until completely intoxicated.

Has Also Used:
Denies Abusing Other Substances

Jenny denies ever having been sexually, physically or emotionally abused.
Jenny denies any problems associated with anger.

Past Psychiatric History:

**Dimension 3: MENTAL HEALTH RISK RATING: 1,** as evidenced by:
Client has a diagnosed but stable mental health disorder that requires intervention but does not significantly interfere with functioning or participation in treatment. Impulse control is good and there are adequate coping skills. Severity is mild and client is not considered an imminent danger to self or others.

Global Assessment of Individual Needs:
Jenny reports that she has the following:
*Sleep Difficulty: Within the Past Month
*Victim of Abuse: Never

Treatment History:
Jenny reports the following treatment history:
Prior Care Setting: Susan Jones, MD

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

Reliability of Information:
Information received seems reliable.

Suicidality:
Jenny convincingly denies suicidal ideas or intentions.

Self Injurious Behavior:
Jenny describes impulses or behaviors that are dangerous or risky and represent a danger to self. She reports driving unsafely. Details are as follows: Jenny reports driving while intoxicated with children in her car.

Danger to Others:
Jenny convincingly denies current danger to others due to homicidal, aggressive, violent, or destructive impulses or ideas.

Withdrawal Symptoms:
Jenny denies ever experiencing withdrawal symptoms.

Social/Developmental History:
**Dimension 4: TREATMENT ACCEPTANCE RISK RATING: 2,** as evidenced by:
Client displays verbal compliance, but lacks consistent behaviors; has low motivation for change; and is passively involved in treatment.

Defense Mechanisms: Jenny minimizes the impact or severity of her illness.
Motivation for Change: Fair.
Addictive Behaviors: Jenny describes alcohol problems, as are elsewhere described.
Self Help Groups Attended: None

**Dimension 5: RELAPSE POTENTIAL RISK RATING: 2**, as evidenced by:
(A) Client has minimal recognition and understanding of relapse and recidivism issues and displays moderate vulnerability for further substance use or mental health problems. (B) Client has some coping skills inconsistently applied.

Relapse History: Jenny reports that this admission is relapse related.
Relapse Triggers: Jenny reports that current relapse began with her exposure to a small amount of alcohol.
Jenny reports that her longest period of sobriety is less that two years.

CD Residential Treatment History: Jenny reports having undergone chemical detoxification/CD Residential Treatment on two previous occasions. She has been treated in the following program: Holly Hill Hospital.

Treatment results are considered satisfactory. Sobriety has been maintained. Sobriety lasted for three months.
12 Step Programs: Jenny attends AA. She "sometimes" attends meetings. She has a sponsor.

Health and Behavior:
Jenny describes the following health and behavior practices:
Diet:
*Eats a healthy and varied diet.

Legal History:
Jenny's legal history is as follows: two DUIs.

Lethal Items in Home:
Jenny denies that there are any lethal items in the home environment, such as firearms or dangerous prescription medicines.

Support System:
Jenny has the social support of the following:
Spouse:
*Highly supportive
Sponsor:
*Highly Supportive
A religious congregation,
*Moderately Supportive

Employment History:
Jenny is working as a beautician .
She has been employed at this job for more than 15 years. Work quality is described as fair.

Strengths/Assets:
Jenny's strengths and assets are as follows:
Cognitive:
*Verbal
*Can make needs known
*Artistic

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

Family History:
Sister completed suicide by drowning.
Brother hospitalized for bipolar disorder.
Cousin treated as out patient for alcoholism. This family member is paternally related.
Jenny's family psychiatric history is otherwise negative. There is no other history of psychiatric disorders, psychiatric treatment or hospitalization, suicidal behaviors or substance abuse in closely related family members.

Medical History:

**Dimension 1: INTOXICATION / WITHDRAWAL RISK RATING: 1**, as evidenced by:
Client can tolerate and cope with withdrawal discomfort. The client displays mild to moderate intoxication or signs and symptoms interfering with daily functioning but does not immediately endanger self or others. Client poses minimal risk of severe withdrawal.

Information Received From:
Jenny

Drug Used:
Alcohol: The following are described:
*Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home.
Tolerance:
*A markedly diminished effect with continued use of the same amount of alcohol.

Impression:
Jenny has 2-3 of the above symptoms/behaviors, therefore she is considered to have a Mild Alcohol Use Disorder.

Length of Use:
Days Since Last Used: About Three Weeks

Precipitating Events:
*Relapse was in part due to negative peer pressure.

Withdrawal Symptoms:
Jenny denies ever experiencing withdrawal symptoms.

Dimension 2: **BIOMEDICAL CONDITION/COMPLICATION RISK RATING: 2**, as evidenced by:
Client has some difficulty tolerating and coping with physical problems. Problems may interfere with recovery and mental health treatment. This patient may neglect care of serious problems.

Psychotropic Med History:
Psychotropic medications have never been prescribed for Jenny.

Currently Prescribed Non Psychotropic Medications:
Lasix with KCL supplement.

Medical Screen:
Infection or Disease:
*None: There are no indications of current infectious disease or recent exposure to an infectious disease.

Exam: Jenny appears calm, attentive, casually groomed, but looks unhappy. She exhibits speech that is normal in rate, volume, and articulation and is coherent and spontaneous. Language skills are intact. Signs of mild depression are present. Thought content is depressed. Body posture and attitude convey an underlying depressed mood. Facial expression and general demeanor reveal depressed mood. Jenny denies suicidal ideas. Affect is appropriate, full range, and congruent with mood. Associations are intact and logical. 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.

Suicidal ideas or intentions are denied. Homicidal ideas or intentions are denied. Cognitive functioning and fund of knowledge are 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. Vocabulary and fund of knowledge indicate cognitive functioning in the normal range. Insight into problems appears fair. Judgment appears fair. There are no signs of anxiety. There are no signs of hyperactive or attentional difficulties. Jenny made poor eye contact during the examination. Jenny exhibits signs of withdrawal from a chemical. She is tremulous.

Diagnoses:.
Alcohol Use Disorder, Moderate, 303.90 (F10.20) (Active)
Hypertension, Essential, 401.9 (Active)

Instructions / Recommendations / Plan:

An Intensive Out Patient program is recommended because a structured, multidisciplinary intervention is needed but there is minimal life threatening danger to self and/or others.
Substance Abuse Counseling
Encourage all activities
AA
Jenny will begin to implement a sobriety plan.
Return Daily in IOP Program

NOTES AND RISK FACTORS:
History of Subst. Abuse
History of showing up late for AA meetings.

90791 Bio-Psychosocial Initial Assessment

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

Session start: 8:00 AM
Session end: 8:45 AM

Mary Williams, LCSW

Electronically Signed
By: Mary Williams, LCSW
On: 7/1/2015 1:32:22 PM