Sunny Dale Counseling
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Jane Doe | Chart ID: 0006 | DOB: 07-08-19

SOAP Note | Encounter Date: Friday, July 8, 2022

Subjective

SYMPTOMS REPORTED:
Depressive Symptoms: Symptoms of depression are being reported or described. Crying spells occur frequently. Excessive worrying is an issue. Episodes of fatigue are reported. Jane struggles with feelings of worthlessness. She often has trouble thinking. Disturbed sleep is a problem for Jane.
Anxiety Symptoms: Symptoms of anxiety are being reported or described. She often becomes anxious. Jane feels apprehensive. Confusion is brought on by increased anxiety. A racing heart is described. She has shortness of breath caused by anxiety. Jane may frequently demonstrate avoidance due to a rise in anxiety levels.

CURRENT STRESSORS:
Serious problems at work are reported. Her emotional state has affected her work. Personality conflicts at work are described. Jane's work problems have resulted in the possible loss of her job. A serious relationship problem is reported. She is experiencing significant relationship strife. Jane has recently experienced a separation from a significant other. Significant social problems are present. Jane's emotional state has affected her social life.

Objective

SYMPTOMS OBSERVED:
Depressive Symptoms: Symptoms of depression are evident. There is an apparent lack of concentration observed. Jane appears to be sad. Jane is tearful during the session. She demonstrates trouble thinking. Jane expresses a sense of worthlessness. Jane denies having suicidal thoughts.
Anxiety Symptoms: Symptoms of anxiety are evident. She is visibly anxious. Jane is apprehensive. She is avoidant. Confusion related to anxiety is observed. She was short of breath at times. She was visibly sweating. Jane fainted during the session.

BEHAVIOR:
Medication has been taken regularly. Her self-care skills are reduced and less attention is being paid to grooming. She is socializing less with family and friends. Functioning at work is impaired. Her anger is well controlled. There have been fewer instances of impulsive behaviors, but some are still occurring. Jane's food and water intake is diminished. Jane is sometimes confused. Sleep problems are present. Jane has difficulty falling asleep. Jane has difficulty staying asleep. Jane reports early awakening.

Assessment

MENTAL STATUS EXAM:
Jane presents as sad, distracted, disheveled and anxious. Signs of moderate depression are present. Demeanor is sad. She is tearful. Thought content is depressed. Her affect is appropriate to verbal content. Associations are intact. There were no signs of psychotic symptoms this session. Suicidal ideas 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 signs of anxiety. She is easily distracted. Jane made poor eye contact during the examination.

RATING SCALES:
The GAD-7 Test:
The GAD-7 is a self-administered questionnaire and screen to detect and determine the severity of Generalized Anxiety Disorder. Jane obtained a result between 15-21, suggesting a Severe Anxiety Disorder. Scores above 10 suggest the need for further evaluation. Her exact score is 20.
The PHQ-9 Test:
Jane was administered the PHQ-9 depression assessment test. She scored between 15-19, indicating that a Moderately Severe Depression is present. Her exact score is 19.

SUICIDE/VIOLENCE RISK ASSESSMENT:
History of Risk Factors:
Jane has a history of the following risk factors:
*History of Abuse: Physical abuse
Current Risk Factors:
*Experiencing Severe Anxiety or Panic
*A Major Depression is Present
Protective Factors:
*Has Beloved Pets
*Good Family Support
*Feelings of Responsibility to Children, Family, or Loved Others
Suicide Risk Assessment:
She denies suicidal ideas or intentions.
Suicide Risk:
Based on the absence of risk factors, Jane's current risk of suicide is considered Very Low or Absent. There are no suicidal ideation or self-destructive or aggressive thoughts or actions.
Violence Risk:
Based on the risk factors reviewed, Jane's current risk of violence is considered Absent or Very Low. There is no homicidal ideation or intention. No aggressive ideation, self-injurious intentions, or ideation within the past six months prior to this instance of treatment.
Access to Lethal Means:
Access to lethal means was discussed with Jane. She denies having access to lethal means at this time.

Plan

RECOMMENDATIONS:
Cognitive therapy is recommended for Jane twice per week. Clinician also recommends that Jane be connected with available community resources for depression and anxiety.
Follow Up: 2x per week

John Smith, LPC