Initial Diagnostic Interview and Biopsychosocial History – 90791/H0031-HO

Date of intake: XX/XX/XXXX
Client Name: XXXXX XXXXXX
Member's Age/gender: age XX DOB XX/XX/XXXXX female/male
Guardian: Biological mother – biological mother has physical custody.

"Why now" for referral to outpatient therapy: Referral for outpatient stabilization post inpatient stay for self harm. Client recently experienced a reoccurrence of symptoms after seeing extended family she had not had contact with for several years and started 9th grade. Client experienced increased conflicts with her mom, increased migraine headaches and inability to sleep leading to feelings of hopelessness.
Chief Complaint/Presenting Problem: The client has an extensive sexual abuse history beginning at age 7. She reports having strong urges to self-harm for over a year and was recently hospitalized at Bryan LGH from xxxx to xxxx for suicidal ideation after a possible suicide attempt which required 7 sutures for a cut on her left wrist. Client stated during the interview that she wants to feel happier and less fearful and is encouraged to make further changes after the coping skills she learned during her inpatient stay.

Family Dynamics: Client lives with her biological mom and mom's boyfriend in a small two-bedroom apartment in the North Bottoms area of Lincoln. Client and mother report they have a good relationship and client reports a good relationship with mother's live-in boyfriend. Extended family members live in Lincoln and client reports supportive relationships. Client's biological parents divorced when she was 8 due to her mother's discovery that her husband was sexually abusing the client. Client and mother experienced domestic violence by one of mom's former boyfriends while he was intoxicated.

Mental Health History (see intake document for specific history): Client previously saw another provider, Dr. x at xxx Agency for 2 years but did not feel she made progress. Recent hospitalization for self-harm and at discharge from the hospital she requested an appointment with this agency and a new provider. Her psychotropic medications are prescribed by her primary care physician in consultation with a child psychiatrist to avoid drug interaction with the pain relievers she takes for her migraines. A list of medications, doses, frequency, and dates is including in a separate chart labeled "Client Medications" attached to the client file. Current medications are Sertraline 50 mg, hs and Imitrex 25 mg prn.

Medical History (see intake document for history): Client sees Dr. x as primary care physician who has prescribed xxxxxx for the migraines. No allergies or food sensitivities were reported.

Substance Abuse History (see intake document)
Client denies use of alcohol or cigarettes. She reports trying cigarettes and beer at age 13 but only the one time. Client denied use of any other drugs.

Academic History: The client is in the 9th grade. Her grades are typically C's; however, she has failed Algebra I. She has never been identified for special education. She reports missing

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school often due to severe migraine headaches. No concerns reported regarding peer relationships.

Personal Assets and Liabilities/Coping Skills Used: Client listed the coping skills she learned while inpatient the skills she uses daily. Client enjoys reading and is able to go to the library independently. The client describes herself as spiritual rather than religious. She reports occasional participation in religious activities with extended family and friends.

Mental Status

The client is a 14-year-old female Caucasian, approximately 5'5", appearing to be somewhat underweight. She was dressed in age appropriate clothing including a knit shirt, blue jeans, and tennis shoes. Hygiene was adequate. Her curly brunette hair was cut short. She does not wear glasses. She presented as neat, clean; she was on time for her appointment.

Her speech was slowed, with a deliberate choice of words. Her eye contact was fleeting. She sat straight up in her chair, with her hands clasped in her lap except to gesture occasionally to make a point. Her affect was appropriate and mood was neutral for most of the interview, with sad affect and tears at one time during the interview.

She was oriented to person, place, time, date, and day. Thought processes were logical and content was appropriate. Her body language and motor movements appeared somewhat stiff and controlled; no agitation of feet or restless hands. Insight and judgment were normal; no evidence of impulse control issues. Her concentration and memory were somewhat impaired when asked to count backward by 7's; she was able to repeat words in order without error and interpret common proverbs appropriately. No evidence of delusions, loose associations, flight of ideas or thought blocking. Her behavior throughout the interview was cooperative.

She denied any homicidal ideations or suicidal ideations or plans at this time. When questioned about her hospitalization for cutting her wrist, she began to cry, insisting she wasn't trying to kill herself; she wanted to feel "better." In the past scratching her skin until she could see blood seemed to make her feel calmer, but this time it didn't work so she cut harder.

She reports flashbacks of being frightened in the dark and these occur only occasionally at night. Client reports of feeling emotionally upset when reminded of stressful experiences rated as moderate prior to hospitalization and currently only occasionally. Member attempts to avoid thoughts and feelings that remind her of the stressful experience are moderate when she is with family but not at all while in school or with friends. She reports that she knows she did not do something wrong to cause the experiences she had. She has lost interest in spending time with family because it reminds her of the trauma but feels this is less since she was in the hospital. Feeling alert or jumpy mostly occurs before going to bed at night and no experience of feeling on guard is reported at school. She reports that she learned coping skills to help her manage feedback without being irritable while in the hospital but reports some moodiness at times with this. She reports that sometimes when she is moody she does get a migraine headache. (Assessment based on National Stressful Events Survey PTSD Short Scale, NSESSS)

Baseline of the CHI-C completed by client's mom indicates client not limited in school activities or energy to do things such as riding a bike, bending or lifting. School absences are related to inpatient hospitalization with a total of 5 missed days of school within the last 4

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weeks. Mother noted that she strongly agreed her daughter is hopeful about her future and has a strong support system. Mother also agreed that her daughter is able to cope with problems. Mother noted that client reports feeling jittery or restless some of the time, however no trouble sleeping or irritability. Higher scores appear related to stabilization during recent hospitalization and require close monitoring.

DSM 5 Diagnosis:
309.81-Post-Traumatic Stress Disorder;
296.22 Major Depression, moderate, single episode (recent inpatient stabilization)
G43 Migraine headaches with aura
995.54 Child Physical Abuse, confirmed,
Initial 995.53 Child Sexual Abuse, confirmed, initial

Treatment Recommendations:

- This client may benefit from cognitive behavioral outpatient therapy to address symptoms of distress related to past trauma, depression and self-harm behaviors. Individual therapy with consultation with family and/or family therapy session one time a week with re-evaluation at the end of two months.
- Relaxation therapy and cognitive behavioral outpatient therapy should be utilized to address symptoms of anxiety.
- A safety plan should be created for protection in case cutting behavior continues or worsens. Risk factors include victim of sexual abuse, physical abuse and inpatient behavioral health admission. The CHI-C and the NSESSS need to be reassessed at the end of two months.
- Discharge based on assessment of reduced distress related to stressful events. Taper sessions as coping skills used. Discharge plan to include return to therapy when increase in symptoms.
- Educate parent regarding cycling potential of past traumatic events and monitor for depression symptoms.
- The family will go the emergency room or call 911 in the event of an emergency.
- Suggested supports include homework outside of sessions such as mood charts, triggers to flashbacks and coping skills used. It does not appear that contact with school staff is necessary unless reports of increased absences due to migraines. Suggest exploring ways to increase physical activity or extracurricular activities through school.
- Review of psychotropic medication is required; a subsequent appointment should be scheduled and a release from her PCP obtained.

Clinician signature

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Signature/License/date

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