PRETREATMENT ASSESSMENT--EXAMPLE

Biopsychosocial Assessment (H0002) (H0002-52)

CLIENT NAME / D.O.B / MEDICAID NUMBER **DATE OF PTA**
GUARDIAN NAME
GUARDIAN PHONE NUMBER

Client Information provided by: Client in session; collateral information from intake questionnaire, discharge information from Bryan LGH

1. Presenting Problems

The client has an extensive sexual abuse history beginning at age 7 which led to the development of PTSD. She reports flashbacks of being frightened in the dark, has a history of self-harm, problems with socializing, and low self-confidence, difficulty sleeping well, severe migraine headaches, and complaints of depression. She has strong urges to self-harm which began last year. The most recent episode led to hospitalization 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. She wishes to begin outpatient therapy; per the client, she would like to "feel normal for once in my life", end self-harming, address her trauma issues, and improve her self-esteem.

2. Social History:

The client is a 14 year old Caucasian female, born in California, now living in Lincoln, NE. Her primary language is English. She lives with her mother. The client is enrolled in 9th grade at Get Smart High School. She takes regular classes and has not been identified for special education. The client's mother reported, the client typically earns grades of "C's", however, within the last year she has failed Algebra I.

Her parents divorced when she was 8 due to her mother's discovery that her husband was sexually abusing the client. Her mother moved them back to Lincoln from California in fear for her daughter's safety. The first year in Nebraska the client and her mother lived in the basement of a cousin's home until enough money was saved for the deposit on an apartment. From age 9 to the present, she has lived with her mother in a small two-bedroom apartment in the North Bottoms area of Lincoln. Although the building was old, the client describes her mother as "a clean freak" and their place as always clean and neat.

3. Family Dynamics:

The client is an only child. She has not had contact with her father since the divorce and does not know where he is located. Her mother has refused to discuss him with her. Her mother has had two different live-in boyfriends when the client was between the ages of 9 and 11; one of them was arrested for domestic violence after beating both the mother and the client while he was intoxicated. He was not allowed to return to the home; the mother changed the locks and took out a protection order. The client has a good relationship with mother's current live-in boyfriend.

No history of incarceration or legal issues for the client or her mother.

The mother began work at one of the ACE hardware stores in Lincoln about three months after arriving from California and still works there today. Neither client nor mother has a record of mental health treatment or treatment for substance abuse.

4. Mental Health History:

The client experienced sexual abuse from her biological father and physical abuse from one of her mother's boyfriends. She previously saw another provider, Dr. x at xxx Agency for 2 years but felt she was not making any progress as her flashbacks continued. Self-harm continued and escalated as evidenced by her recent suicide attempt by cutting her wrist. At discharge from the hospital she requested an appointment with this agency and a new provider.

Her symptoms include elements of PTSD: she reports flashbacks, has a history of self-harm, suicidal ideation, problems with socializing, low self-esteem, severe migraine headaches, and complains

of depression. Depressive symptoms include poor appetite, difficulty sleeping well, extreme fatigue, and feelings of sadness and emptiness. Until the most recent episode she had not required hospitalization for self-harm which had taken the form of scratching with a razor blade on her arm just enough to draw blood.

Her psychotropic medications are prescribed by her primary care physician in consultation with a child psychiatrist to avoid drug interaction with the narcotic 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.

5. Academic and Intellectual 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 school often due to severe migraine headaches which began at age 13 with puberty and appear to be connected to her menstrual cycle.

6. Medical History

The client reports no development issues. Her mother stated she was an early walker. During childhood she had the measles, a cut on her foot from stepping on a piece of glass barefoot which required stitches, no broken bones. She was not a physically active child, preferring to read or color, playing alone with her stuffed animals. At puberty (around age 13) she developed classic migraines with a pre-onset aura warning and severe pain and nausea. She sees Dr. x as primary care physician who has prescribed xxxxxx for the migraines. She denies taking any over the counter medications other than a multivitamin and believes she is healthy. No allergies or food sensitivities were reported. She denies any sexual experiences with partners, stating she has not dated and is not interested in dating.

7. Legal History

The client doesn't know if her father was arrested or tried for sexual abuse; her mother refuses to talk about the incident and the client has not pursued the topic as it "makes me nervous to think about what he did".

8. Offender Issues

She has no offender issues in her background.

9. Victim Issue

The client was physically abused by one of her mother's live-in boyfriends when she was age 11. He was arrested and a protection order was issued for her and her mother. She admits there was sexual abuse from her father ages 6 to 7. However, at this time she prefers not to give details until she decides whether she wishes to continue working with this therapist. Quote: "It's so hard to talk about it; I don't want to go there yet." She denies any neglect or emotional abuse from her mother.

10. Substance abuse history: If the client is age 12 years and over, a substance abuse evaluation needs to be completed to include nicotine, caffeine, alcohol as well as illicit misuse of prescribed and over-the-counter drugs

Substance	*Amount*	*Frequency*	*Duration*	*First Use*	*Last Use*
Tobacco	*Reported trying cigarettes*		*once*	*Age 13*	
Alcohol	*Reported trying beer*	*1 beer*	*Once*	*Age 13*	
Marijuana	*denied*				
Opioids/ Narcotics	*Medication as prescribed*				
Amphetamines	*denied*				
Cocaine	*denied*				

Hallucinogens	*denied*				
Others:	*denied*				
Caffeine	*Reported use*	*Can of soda*	*Daily*	*Age 12*	*9 am today*

She states she doesn't smoke or drink because that was the behavior of her mother's abusive boyfriend. She admits she tried beer once but didn't like the taste. Her mother neither smokes nor drinks; there was never any liquor in the house after the incident with the abusive boyfriend whom she describes as a "lush."

11. Personal Assets and Liabilities

The client describes herself as spiritual rather than religious, adding that she does attend Methodist church services with her mother on special occasions such as Christmas and Easter because it pleases her mother. She says she follows the Golden Rule and believes in karma, that "what you do will come back to you so you should be fair." She 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.

Her favorite past time is reading; goes to the library near her home. She also enjoys going to Barnes and Noble and looking at the new book releases. She reads all types of books from non-fiction to poetry. She rents DVDs from Netflix and watches them with a girlfriend.

Her support system includes her mother, her mother's present boyfriend, and a girlfriend. She states she is fine with having a few good friends she can trust.

The client has recently begun babysitting a six-year old neighbor boy on Friday nights.

Coping skills appear to have been adequate until the recent increase in depressive thoughts and feelings of unworthiness leading to the exacerbation of her self-harm which required hospitalization on xxxxx.When asked if anything had changed in her life recently, she could not pinpoint an event, only that she had experienced nightmares the past month in which she was running from a "creeping blackness, like oil spreading on the ground." The nightmare theme has been repeated.

She admits being frightened at the severity of cutting her wrist; quote: "I don't think I really want to die; I just want to feel better." Her strengths include a supportive female friend, family involvement with her mother, and mother's current boyfriend. Client is intelligent, wishes to work in therapy to resolve her issues and become less depressed.

No challenges exist to follow up; transportation is not an issue. An appointment for the Initial Diagnostic Interview with Dr. XX is scheduled for (date). She will return to this office for a follow up appointment on (date). A crisis plan was created with her to address her cutting behavior.

Our discharge criteria will include the client achieving the goal/objective of demonstrating a reduction in depressive symptoms by 60% and zero incidents of self harm. Client will also have increased comfort in social situations 80% of the time and take any medications as prescribed. Client's transition plan to discharge will include increasing her involvement in the following explored community activities: Divorce support group; Career Search class at Community College; return to Mary/Martha group at church and other previous social activities, including hanging out at Barnes and Nobles; Bibliotherapy—workbook pages; handouts; titles of books to read outside session. Client will discharge from therapy with ongoing medication checks, regular involvement in daily attendance at school and regular involvement in at least two of the agreed upon activities.

Therapist Signature/Date_____ Supervisor Signature/Date_____

Initial Diagnostic Interview (90801)

Mental Status Exam

Appearance: Age-appropriate, adequate hygiene
Affect: Constricted
Orientation: Oriented X4
Mood: Depressed/Anxious
Thought Content: Appropriate
Thought Process: Logical
Speech: Normal
Motor: Slowed
Intellect: Average
Insight: Partially Present
Judgment: Limited
Impulse Control: Limited
Memory: Intact
Concentration: Within normal limits
Attention: Within normal limits
Behavior: Cooperative
Thought Disorder: No Problems Noted

Risk Assessment

	None Noted	Thoughts Only	Plan (describe)	Intent (describe)	Means (describe)	Attempt (describe)	Able to Contract for Safety
Suicidal Ideation		Denies					Yes
Homicidal Ideation	None						

Risk Factors:

- ____ Non-compliance with treatment
- ____ AMA/elopement potential
- __x__ Prior behavioral health inpatient admissions
- ____ History of multiple behavioral diagnosis
- ____ Suicidal/homicidal ideation

____x__ Domestic Violence
_____ Child Abuse
____x__ Sexual Abuse
_____ Eating Disorder
_____ Other (describe)

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 seemed somewhat slowed, with a deliberate choice of words. Her eye contact was fleeting, but not unusually so. She sat straight up in her chair, with her hands clasped in her lap except to gesture occasionally to make a point. Her mood was neutral for most of the interview, lapsing into sad

affect and tears at one time. Her affect was appropriate; 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 stated she was scared and wanted help; her previous therapist didn't understand her "…. probably because he is a man, I need to talk to a woman."

She related her background with the same information found in the Pre Treatment Assessment, describing her self as "kinda solitary" but not lonely. She revealed that she had been sexually abused by her biological father from ages 6-7 but refused to elaborate. She related the events of the physical abuse she and her mother went through at the hand of one of her mother's boyfriends.

Symptoms of depression elicited were increasingly poor appetite, difficulty sleeping well, repetitive nightmares, extreme fatigue, and feelings of emptiness that nothing really mattered anymore. She stated that she had been prescribed Prozac for several months but couldn't tell any difference in her mood. When questioned she could not tie her mood change to any current incident in her life.

In Summary: This 14 year old girl demonstrates increasing depression and anxiety as evidenced by the symptoms of poor appetite, difficulty sleeping well, repetitive nightmares, flashbacks, extreme fatigue, and feelings of emptiness. Her recent episode of cutting is also an increase in previously somewhat benign self-harm behavior in the past. She has a history of sexual and physical abuse as a child which may be of significance to her current mood status at this time in her life.

Diagnosis:

309.81-Post-Traumatic Stress Disorder
296.22 Major Depression, moderate, single episode
Migraine headaches reported
995.54 Child Physical Abuse, confirmed, initial
995.53 Child Sexual Abuse, confirmed, initial

2. Treatment Recommendations:

This client may benefit from cognitive behavioral outpatient therapy to address the recent increase in depression and self-harm behaviors. At this time individual therapy is most appropriate, 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.

Administration of the Beck's Depression Inventory and another measure of depressive thought patterns would be helpful to determine current baseline symptoms.

Due to the client's introverted nature and recent events, explored referral to a small divorce group, Parents United or another smaller support group or a class to learn a hobby where client needed only to listen.

Review of psychotropic medication is required; a subsequent appointment should be scheduled and a release from her PCP obtained.

Supervisor/ Diagnostician Signature/Date

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