INTAKE NOTE (Longer Note)

NAME: Smith, John
DATE: January 1, 2001

John Smith, MD, a 45 year old married Caucasian man presented with concerns about depression. Pt presented in no apparent distress for his scheduled appointment, appropriately dressed and groomed. Pt reported that he has "been feeling blue for a few months now and [his] wife really thought I should speak with someone." Pt initially minimized his emotional experience reported that he was simply "blue" and "melancholic" but later reported that he had early morning awakenings, impaired concentration, increased alcohol consumption, and suicidal ideations. No collateral information was obtained from outside sources, but Pt appeared to be a reliable historian.

Pt reported that about 5 months ago he was promoted from Assistant to Associate Professor, and with the promotion came additional demands on his time. Around the same time he and his family moved from the City to the northern Baltimore County. Shortly after this time he noticed that he was feeling more fatigued but attributed the decreased energy to work and the move. Over the past few months he has felt increasingly worse physically and emotionally, and has contemplated suicide for the first time.

Pt reported that he was treated for depression once before, during his first year of medical school. He moved from his hometown college in the mid-west to Boston to attend Harvard Medical School. He felt overwhelmed by the demands of medical school, though his academic performance was never questioned by his instructors. By Christmas break he felt very depressed and anxious, and sought counseling though his university Counseling Center. He saw a psychiatry resident for therapy for about 6 months, and remained on a TCA for about a year. He was satisfied with the treatment he received and felt the depression resolved fully. Pt has never been hospitalized psychiatrically.

Pt reported that he typically drinks a glass of red wine with dinner every other night or so, and he will drink up to three cocktails at parties. However he reported that since feeling depressed he has decided to stop drinking temporarily, and thus has not consumed any alcohol for a couple months. He reported that in college he experimented with marijuana, but this was never excessive nor problematic. Pt denied use of cigarettes, though he occasionally smokes a cigar. He typically consumes 2-4 caffeinated beverages per day. He has never required substance abuse treatment.

Pt's parents are alive and well, and they remain married to each other. His entire family of origin remains in the mid-west where Pt grew up. Father, who is now 72, retired from his factory job several years ago. Mother, 68, still works part-time as a secretary in a medical office. Pt reported that he is close with his parents, and speaks with them twice weekly. Pt is the youngest in a sibship of three. His 48 year old brother is an auto mechanic, and is currently "between jobs" and in the process of being divorced. His 46 year old sister is a nurse and is married with two children. Pt is closer with his sister than his brother. His

sister was treated for depression and anxiety a few years ago, though the details of her treatment were vague. Pt stated that he believes his sister was prescribed an SSRI. Pt has been married for 17 years, and describes his relationship as supportive, though not very affectionate or intimate. He and his wife typically have sexual relations once or twice a month, and this frequency has been unsatisfying to him, though the couple has done nothing to change. They have two daughters, ages 15 and 13, and both are doing well in private school. Pt has many friends and social acquaintances thought work and otherwise. His closest friend, other than his wife, is a buddy from college who recently moved from the east coast to the mid-west.

Pt reported no birthing or developmental problems. He denied a history of abuse or neglect in the family home. He denied a history of antisocial behaviors as a child, adolescent, or adult. Pt was a good student through high school, and after a difficult time adjusting to college, he thrived and made Dean's List nearly every term though medical school. He completed his residency in Internal Medicine after which he accepted a faculty appointment at JHU. He was recently promoted from Assistant Professor to Associate Professor. He enjoys his work, though he works longer hours than he ever anticipated, and feels overwhelmed by excessive demands on his time. He has had no discipline problems, and reports that he is well respected among his colleagues. Pt has never served in the military.

Pt has a strong and supportive support system comprised of his wife, extended family, and friends at work and otherwise. In the home are Pt, his wife, and their two daughters. His older daughter had a school friend staying in the home for about a month up until a week ago while her friend's mother was in treatment for alcoholism. Pt denied a history of arrests or other legal involvement other than several minor speeding tickets over the years. He denied a history of violence toward, or at the hands of, anyone, though he reported that when he was a boy his father regularly spanked him and his brother but not their sister. Pt purchased a .38 special revolver a few years ago, after a friend took him to target practice. The weapon is kept in a lock box in the basement with ammunition stored separately. The family is financially secure, though he noted that he earns a significantly smaller salary than his former medical school peers who are in private practice. Pt reported that he used to enjoy racing bicycles, and other outdoor activities, but he hasn't had the time to do these things recently. Instead he finds that his recreation time tends to be scheduled by his wife, and revolves around weekend dinner activities with other couples. Pt described himself as an "easy-going guy who is just worn out" and added that others have noticed that he is frequently tired and less socially active.

Pt reported that he has not had a physical in years and that he does not have a regular primary care physician. Instead, he tends to self-medicate when he contracts minor colds or flues. The last time he had blood work done was probably about 3-4 years ago. Pt takes Flonase as needed for chronic recurrent sinusitis, and a daily multi-vitamin. He denied use of other prescription or over-the-counter medications, herbal supplements, or diet aids. Pt reported that he is in fine health other than the above-mentioned sinusitis and recent complaints of fatigue. He denied history of major illness or disease, though he reported he was involved in a motor vehicle accident 8 years ago in which he lost

consciousness for about 15 minutes and sustained a concussion. Follow up CT of his head several weeks later was normal. Pt denied history of surgery and reported no known drug allergies.

On examination, Pt was alert and fully oriented. His speech was of normal rhythm and volume, though a bit slowed. He evidenced no abnormal tics or tremors. He was pleasant and cooperative, and was appropriately dressed and groomed. Pt evidenced no signs of thought disorder or psychosis. Thought process was logical and goal-oriented, and thought content was free of hallucinations, illusions, or delusions. Pt reported that he has felt excessively fatigued lately. He has been falling asleep shortly upon coming home and has had trouble getting out of bed after more than 8-10 hours of sleep. He usually requires only about 6-7 hours of sleep per night and never naps. Pt reported that he has noticed that he has been skipping lunch, and sometimes dinner because he has not had much of an appetite lately. He was not sure about weight loss, but has noticed that his clothes are not as snug or well-fitted lately. Pt is slightly slowed motorically, and feels that he just can't move as quickly as usual due to his fatigue. He denied crying spells. His stated mood was "blue and perhaps a bit melancholic". Affect was congruently depressed and relatively narrow in range. He reported no history of mania or hypomania. He confessed that he occasionally feels his family would be better off financially if he somehow died, but denied active suicidal ideations, plan, or intention. He denied a history of such behaviors either, and also denied homicidal ideations as well. He later was able to state that though his life insurance would be helpful to the family, they would be sad if he died, and as such he has never allowed himself to entertain suicidal thoughts. He exhibited moderate "psychological pain", moderate "pressures/stressors", and low "agitation", and is thus assessed, in light of history and protective factors, to be a low suicide risk at this time. Pt reported that he has not found socializing as enjoyable as he had in the past, and felt that he "brought down" his family during the recent winter holidays. Pt expressed a future orientation, but little hope that he will feel better. Pt is estimated to be of significantly above average intelligence, but reported that he has had difficulty focusing and sustaining concentrating. He added that his memory has been "off" recently as well. Pt evidenced adequate judgment and impulse control, though he seems to lack insight into his illness.

Initial diagnostic impression is Major depressive disorder, single episode, moderate (296.22) on Axis I; no diagnosis on Axis II; and chronic recurrent sinusitis on Axis III. Pt presented with what appears to be a reactive (likely in response to his recent promotion) and recurrent depression of moderate severity with some suicidal ideation and risk, but overall is assessed as being relatively low risk. Of concern is the recurrent nature of his depression, the severity of it, possession of a weapon, and the fact that when his energy restores he may be more agitated and able to act upon suicidal ideations. Pt has a stable support system, is quite high functioning and has listed multiple protective factors against acting upon suicidal thoughts. In light of the above findings, he was provided a supportive session, offered bibliotherapy (Dr Burns' "Feeling Good"), and a referral for medication evaluation and on-going psychotherapy. He has BC/BS insurance. Referrals were offered to Drs Smith, Jones, and Wilson. Pt was appreciative of FASAP services and referral, and has agreed to contact one or more of the referrals listed. He was

provided my emergency contact information and we completed a "safety card" with the first 4 steps including contacting wife, contacting his high school buddy, going on a bike ride, or taking a nap. Pt is scheduled to return for follow up in one week, at which time we will discuss actions taken toward engaging in treatment.

Clinician Name

[This note is purely fictitious and used for training purposes. Any representation or resemblance to a real person is entirely coincidental.]