INITIAL PSYCHIATRIC EVALUATION - OFFICE

PATIENT NAME	**John Test**	**MEDICAL RECORD NO.**	**4077**
SOCIAL SECURITY	**456-67-7777**	**SECONDARY MRN**	**0**
DATE OF BIRTH	**January 05 , 2007**	**PROVIDER NAME**	**Edward N Childdemo, M.D.**
		VISIT DATE	**March 23 , 2013**

IDENTIFICATION

This is a 6 year old white single male who resides in Miami Beach, Florida. He is currently living with his 36 year old mother, relationship issues are described as aggression.

CHIEF COMPLAINT

Mr. Test presents to our office for Initial evaluation. Patient reported chief complaints as 'does not want to loose parents. ' Primary care provider wanted to have evaluation by psychiatrist.

CURRENT HISTORY

Mr. Test was interviewed with his mother, whose reliability is fair.

ADHD: He describes no major issues with attention and hyperactivity and impulsivity.

AGITATION: John reports being agitated. His symptoms include hollering, wandering, kicking and biting and hitting. He reports the duration has been for > 6 months. His symptoms are of a moderate rated intensity level.

ANXIETY: John complaints of a recent episodes of panic attacks. Duration of panic attacks is reported as 3 to 6 minutes per episode.

APPETITE: He denied issues with appetite.

AUTISM: John presents with pervasive pattern of behavior. His associated symptoms include: impairment in use of eye to eye gaze to regulate social interaction and impairment in use of facial expression to regulate social interaction. Additionally, he presents with aggression. His associated symptoms include: kicks others and bites others. He also presents with generalized anxiety. His associated symptoms include: had difficulty controling worries about bad things happening in future and had difficulty controling worries about how well things are done.

BEHAVIOR: Screaming, duration is reported as > 6 months and crying, duration is reported as > 6 months.

BODY IMAGE: He denied issues of body image.

COMMUNICATION: Total lack of the development of spoken language, duration is reported as > 6 months.

COMPULSIVE: He denied any compulsive behaviors.

CONDUCT DISORDER: His conduct is consistent with disruptive behavior. His associated symptoms includes bullies others and threatens others and physically cruel to animals.

DELUSIONS: He denied symptoms of delusions.

EDUCATION: He deneid issues with learning.

ENERGY: John reports a high energy level.

FEARS: feeling of nervous tension, duration is reported as > 6 months.

GENERALIZED ANXIETY: had difficulty controlling worries about future, duration is reported as > 6 months, had difficulty controling worries about bad things happening in future, duration is reported as > 2 weeks and had difficulty controling worries about how well things are done, duration is reported as > 6 months.

HALLUCINATIONS: John presents with the following hallucinations: reports hearing sounds. His occurrences are reported as intermittent.

HARM TO SELF: He denied issues with self mutilating behaviors.

HOMICIDE: He denied issues with homicidal thoughts and intent or plans.

IMPULSIVITY: He denied issues with impulsivity.

INTERPERSONAL: limited social interactions, duration is reported as > 6 months.

MOOD: John presents with a history of a manic mood type. His associated symptoms include elevated mood and increased energy. He reports the duration has been for > 6 months. His symptoms are of a moderate rated intensity level.

MOTOR: He denied issues with movements.

OBSESSIVE BEHAVIOR: He denied symptoms of obsessions.

OPPOSITIONAL DEFIANT DISORDER: His symptoms include: often loses temper, duration is reported as > 6 months, often actively defies, duration is reported as > 6 months and often refuses to comply with rules, duration is reported as > 6 months.

SELF-HELP: He denied issues with self help.

SENSORY: He denied issues with sensations.

SEPARATION ANXIETY: John's symptoms include afraid of possible harm to his mother most of week, fear of being separated from his mother most of week, phobic of calamitous separation from his mother most of week and rising to check on his mother most of week and shows signs of excessive distress in anticipation of possible harm to his mother everday.

SLEEP: He reports problem going to sleep.

SOCIAL SKILLS: John reports he lacks social reciprocity and lacks emotional reciprocity.

SPEECH AND LANGUAGE: He denied speech and language problem.

STEROTYPED PATTERNS: He denied sterotyped movements.

STRESSORS: John's current stressors include social environment and family issues. The stress level of these stressors is reported as of moderate intensity.

SUICIDE: He denied suicidal thoughts and intent or plan.

THOUGHT CONTENT: He denied issues with thought content.

THOUGHT PROCESS: He denied issues with thought process.

TICS: He denied issues with tics.

TRAUMA: He denied symptoms of traumatic stress.

PSYCHIATRIC HISTORY

INPATIENT MENTAL HEALTH TREATMENT HISTORY:

Mr. Test denies previous psychiatric hospitilization.

OUTPATIENT MENTAL HEALTH TREATMENT HISTORY:

Mr. Test denies previous outpatient mental health treatment.

HISTORY OF HARM TO SELF OR OTHERS:

Mr. Test denies a history of harm to self and denies a history of harm or injury to others.

ADDITIONAL NOTES

PAST HISTORY OF MEDICATIONS

CURRENT MEDICATIONS

Mr. Test's current medications are:

RITALIN 10 Quantity 1/2 RITALIN TABLET 10 MG QD for 30 Days. Prescribed by Primary Care Provider.

MEDICAL HISTORY

He denies any pertinent past medical history.

SURGICAL HISTORY **He denies any pertinent surgical history.**

ALLERGIES **He reports he has No Known Drug Allergies.**

SOCIAL HISTORY **He is residing in a condominium. He is currently living with his 36 year old mother, relationship issues are described as aggression.**

His religious preference is No religion.

John reports the following history of abuse: His father emotionally and physically abused him. The abuse was reported to occur approximately two months ago. He reports the abuse details as his father would lock him in bathroom while his parents fought.

EXPANDED SOCIAL HISTORY:

FATHER: His father is still living.

He felt secure, loved, sense of worth and value as child.

He describes the relationship with father as: uncaring, not understanding, and inconsistent.

MOTHER: His mother is still living.

He felt secure, loved, sense of worth and value as child.

He describes the relationship with mother as: caring, understanding, and consistent.

SIBLINGS: He does not have siblings.

PREGNANCY: His conception was not planned.

His father's reaction to learning of the pregnancy was negative.

His mother's reaction to learning of the pregnancy was positive.

His mother did not have infection/illness during pregnancy.

His mother experienced shocks, trauma, injury or unusual stress during pregnancy.

His mother's age at delivery is reported as: 29 years old.

His mother did not smoke tobacco during pregnancy.

His mother did not use illegal drugs during pregnancy.

His mother drank alcohol during pregnancy.

His mother did not take prescription drugs during pregnancy.

His mother experienced other major stress during pregnancy.

His mother or child did not experience medical complications following delivery.

BIRTH: His birth was full term.

CHILD'S HEALTH: He reports illness or diagnosis as: agitation and aggression.

He has not had psychological testing performed.

He has not had speech and language or audiological testing.

He has had eye examination.

DEVELOPMENTAL HISTORY/CHILDHOOD: He was not adopted as a child.

He had not been identified or diagnosed with illnesses or condition.

His overall level of physical health is reported as: fair.

His overall level of social/emotional development is reported as: fair.

His overall level of intellectual or cognitive development is reported as: fair.

His overall level of physical development is reported as: fair.

SOCIAL - EMOTIONAL: He has trouble getting along with other children his own age.

He seems overly sensitive to criticism.

He seems overly anxious or fearful.

He tends to be quiet or withdrawn.

He tends to be easily frustrated.

He tends to be unusually uncooperative or stubborn.

He does not seem to need more protection from life than other children.

TREATMENTS: He reported the following current treatment or therapy: currently taking Ritalin from family doctor.

CRIMINAL HISTORY **John denies having a criminal history.**

SUBSTANCE HISTORY **John denies a history of alcohol abuse.**

John denies a history of substance abuse.

FAMILY PSYCHIATRIC HISTORY **Mr. Test reports family psychiatric history: His father diagnosis: anxiety and ADHD.**

He denies any family homicidal history.

He denies any family suicidal history.

FAMILY MEDICAL **He denies any pertinent family medical history.**

MENTAL STATUS **John is a 6 year old white male child.**

PATIENT APPEARS: appears to be younger than stated age.

REMARKABLE FEATURES: none.

ALERTNESS: alert.

APPEARANCE: well groomed.

NUTRITIONAL STATUS: well nourished.

HABITUS: average height.

OREINTATION: person(name), place, situation, time.

EYE CONTACT: good.

SPEECH: normal rate, normal tonal variation.

VOICE: appropriate volume.

ATTITUDE AND BEHAVIOR: appropriate, cooperative.

CONATION: exhibited as normal.

ABNORMAL MOVEMENT: There are no abnormal movements noted on exam.

GAIT: grossly intact.

STATION: within normal limits.

MOOD: euthymic, anxious, irritable.

AFFECT: full range.

THOUGHT PROCESS: goal directed.

ASSOCIATIONS: intact.

THOUGHT CONTENT: thought withdrawal.

HALLUCINATION: He is not experiencing hallucinations.

DELUSIONS: He is not experiencing delusions.

INTELLIGENCE LEVEL: normal.

INSIGHT: good.

JUDGMENT: good.

NAMING: intact.

REPETITION: intact.

FUND OF KNOWLEDGE: good.

PROVERB INTERPRETATION: accurate.

SIMILARITIES: intact.

SUICIDAL IDEATION: Mr. Test denies the presence of suicidal ideation.

HOMICIDAL IDEATION: Mr. Test denies the presence of homicidal ideation.

VITALS

HEIGHT	**3 feet 6 inches**
WEIGHT	**60 lbs.**
BODY MASS INDEX	**23.81**
BODY SURFACE AREA	**.94**

MEDICAL REVIEW OF SYSTEMS

A review of Breast, Cardiovascular, Constitutional, Endocrine, ENT, Eyes, Gastrointestinal, Genitourinary, Hematologic Lymphatic, Integumentary, Musculoskeletal, Neurological, Pain, Respiratory medical systems was otherwise non-contributory.

DIAGNOSIS

AXIS I: 309.21 - Separation Anxiety Disorder; 299.00 - Autistic Disorder.

AXIS II: Diagnosis Deferred on Axis II - 799.9.

AXIS III: No contributory medical diagnosis.

AXIS IV: John's current stressors include social environment and family issues. The stress level of these stressors is reported as of moderate intensity.

AXIS V: CURRENT GAF 62.

ADDITIONAL NOTES/DATA

PLAN AND RECOMMENDATIONS

TREATMENT PLAN

TREATMENT PLAN REVIEW

PROBLEM NUMBER: * 1 AGITATION I=Problem incorporated into another problem.

PROBLEM NUMBER: * 2 AUTISM T=To be addressed in treatment.

PROBLEM NUMBER: * 3 HALLUCINATIONS I=Problem incorporated into another problem.

PROBLEM NUMBER: * 4 MOOD I=Problem incorporated into another problem.

PROBLEM NUMBER: * 5 SLEEP M=Problem noted and will be monitored.

PROBLEM NUMBER: * 6 STRESSORS M=Problem noted and will be monitored.

PROBLEM NUMBER: * 7 SEPARATION ANXIETY T=To be addressed in treatment.

IMPRESSION

MEDICATION ORDERS

MODIFY MEDICATIONS

Mr. Test's medication changes are:

*** Discontinue 10 MG RITALIN Quantity 1/2 RITALIN TABLET 10 MG TID for 30 Days Ordered by Primary Care Provider.**

PRESCRIPTIONS

Mr. Test Prescription orders are:

*** Initial 0.25 MG RISPERIDONE TABLET TABLET, COATED ORAL .5 QAM for 30 Days Refills: 0 Dispense: 15 Medication Reason: emotional volatility.**

LABORATORY-TESTS

RECOMMENDATIONS	**Mother and child are recommended for family therapy treatment. Advised father should attend the sessions if he is capable of managing emotions. Mother is advised not to threaten to stop visitations with father unless there is potential harm to mother or child. However, the discussions regarding father should be conducted during therapy session and not direct with child.**
EDUCATION	**We discussed the risk and benefits of the prescribed medications. Additionally, discussed with mother the reason for the prescribed medications and the potential benefit to the patient**
INSTRUCTIONS	**Get Labs: ordered by me, from PCP, or faxed by patient.** **Mother was provided my contact information in the event of an emergency and was instructed to call with a status report on the patient next week.** **Both mother and patient are referred to a therapist.** **Mother was advised to call the clinic in case of worsening of symptoms or emergence of side effects.**
INFORM & CONSENT	**Mother and patient were provided an opportunity to ask any questions regarding medications and treatment plan. After the discussion, the mother signed consent and inform and consent documents for medications.**
FOLLOW-UP	**4 Weeks Brief Follow-up visit, E/M**

PHYSICIAN SIGNATURE

Edward N Childdemo, M.D.