

Harmony Heals, Inc



ID: _____

REF: _____

CC: _____

HPI:

DIAGNOSIS:

I:

II:

III:

IV:

V: GAF=

Depressed Mood
Insomnia/Hypersomnia
Poor energy/fatigue
Excessive/inappropriate guilt
Poor concentration/ attention
Recurrent thoughts of death/SI without a plan/suicide attempt or a specific plan
Homicidal thoughts/plan/Intention:

Loss of interest
wt loss/gain
Appetite
Observable agitation/ retardation
Feeling: worthless hopeless helpless
Poor Sexual desire

Elevated or expansive mood +3:
Grandiose/inflated self-esteem
More talkative/pressure to keep talking
Flight of ideas/Racing thoughts
Increased goal-directed activities/Agitation:
Excessive involvement in pleasurable activities:

Decreased need for sleep
Distractibility

2 for a month:
Delusions
Disorganized speech
Negative symptoms (Flat affect, Alogia, Avolition)

Hallucinations A/V/G/T/O
Disorganized/ Catatonic behavior

Panic Attack:
Chronic Anxiety:
Social phobia:
Specific phobia:
OCD (counting, checking, cleaning, organizing):
ADHD:
Eating d/o (binging, purging behavior):
PTSD (severe trauma, flashbacks, nightmares, avoidance, hypervigilance):

PAST PSYCHIATRIC HISTORY:

Previous Diagnoses:
Admission to psychiatric facility:
Hx of suicide attempt:
Previous Psychiatrist:

PAST PSYCHOTROPICS:

PAST MEDICAL HISTORY:

Surgery:

Fractures:

Head Injury with LOC:

Seizure disorder:

PCP:

ALLERGY:

HISTORY OF SUBSTANCES:

Alcohol: (Hx of DT, BO, Seizure)

Cocaine/Crack/ Methamphetamine

Marijuana:

Inhalants (gasoline, Glue)

PCP/LSD/Mescaline/Mush/Ecstasy/Speed

Heroin/Opioids

IVDA

Prescription drug

Coffee/Soda/Tea:

Smoking:

LEGAL HISTORY:

Jail/Prison Hx:

Pending legal charges:

On Probation:

History of DUI/DIP:

FAMILY HISTORY:

Mother:

Hx of suicide in family:

Father:

Brother:

Sister:

SOCIAL HISTORY:

Born:

Raised:

Place in the family:

Marital history:

Children:

History of abuse as a child (V/Ph/S/M):

Hobbies:

Education:

Occupation Hx:

Access to gun/Owning a gun:

Military experience:

REVIEW OF SYSTEMS: + for :

Menstruation/Pregnancy:

BP:

PR:

Weight:

Height:

MENTAL STATUS EXAMINATION:

AAO X 3

Eye contact:	good	fair	poor			
Activity:	normal	agitated	decreased			
Speech:	normal	rate	tone	volume		
Mood:						
Affect:	euthymic	anxious	dysthymic	euphoric	appropriate/congruent	
	labile	restricted	blunted	flat		
Thought content:	SI:	passive	Active	Plan	Intent	None
	HI:	Passive	Active	Plan	Intent	None
	Halls:	Auditory	Visual	Gus/Olf	Tactile	None
	Dels:	Paranoid	Sexual	Somatic	Bizarre	None
Thought process:		linear	circumstantial	tangential	LOA	Block
Judgment:		good	fair	poor		
Insight:		good	fair	poor	none	

CURRENT MEDICATION:

ASSESSMENT/PLAN:

- Pt is not imminently suicidal, homicidal or acutely psychotic.
- Pt was educated to refer to ER or call 911 in case of emergency.
- Pt is capable to make medical decisions.
- Psychoeducational items were addressed including: substance abstinence, importance of complying with treatment plan, diet, exercise, sleep hygiene measures.
- Medication side effect profile, risks, benefits, and rationale behind this treatment plan was explained to pt.
- Pt verbalized understanding and agreeing with the plan.
- Pt is aware that should contact me in case of questions or concerns.

Lab orders:

CBC, BMP, CMP, UA, Pregnancy test, TSH, lipids, LFT, Drug level of _____
No labs needed currently.

RTC:

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