NextGen Patient Record

Name: Bodin, Jeffrey
DOB: 05/22/1997

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Encounter: 11/9/2017 9:00:00 AM CST

ComprehensiveAsmt - EC

Sinfonía
Family Services of Louisiana

MRN #: 000000001984

Comprehensive Assessment

Client Name: Jeffrey Bodin
Date of Birth: 05/22/1997
Assessment Date: 11/09/2017

PCP/Physician **Phone ( ) - FAX**

Legal Guardian **Phone**

Emergency Contact **Phone**

Sinfonía
Family Services of Louisiana

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Behavioral Health and Medical History Questionnaire

Client Name: Jeffrey Bodin
Date of Birth: 05/22/1997

Are you currently taking any medications (prescription, over the counter vitamins, homeopathic or naturopathic remedies, traditional or alternative medicine remedies, herbs)?

_ No X Yes, answer questions below.

Identify the medications that you are currently taking for medical or behavioral health concerns and the reason for taking the medications below:

Medication Name	Reason

mirtazapine
singulair

Are you allergic to any medications? X No _ Yes, which ones?

Do you have any other allergies? _ No X Yes

If yes, explain: lactose intolera t

Historical Vaccine Information:

DTap: unknown or not reported at this time
IPV: unknown or not reported at this time
HIB: unknown or not reported at this time
Hep B: unknown or not reported at this time
PVC13: unknown or not reported at this time
Rotavirus: unknown or not reported at this time
MMR: unknown or not reported at this time
Varicella: unknown or not reported at this time
Hep A: unknown or not reported at this time
Tdap: unknown or not reported at this time
Meningococcal: unknown or not reported at this time
HPV: unknown or not reported at this time
Flu: unknown or not reported at this time

Any history of head injury with concussion or loss of consciousness? X No _ Yes

Are you currently pregnant? 4 No 4 Yes 4 Unsure
Are you receiving prenatal care? _ No _ Yes
Child Birth within the last 5 years? _ No _ Yes X N/A
Total Number of Births (live and still):

Are there any medical problems that you are currently receiving treatment for?

_ No X Yes, answer questions below.

Describe below what current medical problems you have and what type of treatment you are currently receiving.

Medical Problem

Current Treatment

cluster headaches, peripheral nueropathy, Narcolepsy

Does your current medical condition(s) create problems in how you deal with life, including pain?
__ No X Yes

Do you use tobacco? X No _ Yes
Have you ever received out-patient (office-based) services, been hospitalized or received services in a residential facility for behavioral health concerns?

_ No X Yes, answer questions below

Describe below the type of treatment you received to address your behavioral health concerns and when you received this treatment.

Type of Treatment	When	Where
hospitalization	10/11/17	Northlake

What current or prior treatment/services, including medication, do you think have been the MOST helpful in addressing your behavioral health symptoms? Explain:

What current or prior treatment/services, including medication, do you think have been the LEAST helpful in addressing your behavioral health symptoms? Explain:

List previous physical health diagnosis, surgeries, and hospitalizations including dates and outcome of treatment received:

Narcolepsy, nueropathy,

Presenting Issues

Client Name: Jeffrey Bodin
Date of Birth: 05/22/1997

What are you seeking help for today? Why now?

Depression: sadness, isolation, fatigue, lack of motivation
Anxiety: stress, racing thoughts.
Grandiosity, possible paranoia.

How long have these issues been a concern (onset, intensity, duration, frequency)?

Client was diagnosed with cancer at the age of 10

Family/Social History

Client Name: Jeffrey Bodin
Date of Birth: 05/22/1997

Living arrangements:

Do you need housing assistance: No

Household members and age:

Relation	Age	Month(s)/Day(s)	Name	DOB	Custody	Other Parent	Ethnicity	Sex
father	0		Mark					M
mother	0		Linda					F
sister	0		stephanie					F

Family history of mental illness and/or substance abuse (who and what relationship to client):

Summarize family history and child rearing practices:

Client reports that his family was "fine" growing up. He said his parents fought some, but that seems to be normal for them.

Does someone have custody/guardianship of client? No

Describe the relationships you are involved in and how you feel about these people (family, friends, significant others, community relationships, staff if placed out of home) In general, how do you get along with others?

I get along well with others, especially when I am on a stimulant

Which people are you most comfortable confiding in?
Do you think these people would be supportive and helpful to you at this time?
How do these people help?

None

What are the things that make you feel good about yourself and help make your life meaningful? (interests, skills, abilities, friends, family, values, religion/spirituality, work, school, culture/community)

Program comptuters, play games, read

Sexual Orientation: Heterosexual **Gender Expression:** Male

What do others consider to be your strengths? (including interests, talents, skills and abilities, knowledge/education, friends, family, values, religion/spirituality, your culture/community, work, school, etc.)

Person's Weakness(es)/Area(s) of Opportunity:

exercise. I don't exercise that much

Do you need assistance with self care and/or basic needs?

No

Abuse/Sexual Risk Behavior

Client Name: Jeffrey Bodin
Date of Birth: 05/22/1997

Do you feel safe in your current living situation? Yes

Do you feel safe outside of your home? Yes

Are you currently or have you ever been hurt, harmed, touched inappropriately, or abused by someone in any way? (Consider any physical, sexual, or emotional abuse) No

Is any member of your household/family currently being or has ever been harmed, abused, neglected, or victimized? (Consider any physical, sexual, or emotional abuse.) No

Summarize other relevant trauma history:

Had cancer as a 10 y/o child.

Do you engage in any sexual behaviors that you are concerned about, or that have raised concerns in your family or community (sexual acting out, inappropriate touching, exposure)? No

Have you ever been tested for HIV/STD/TB? No

Developmental History

Client Name: Jeffrey Bodin
Date of Birth: 05/22/1997

Has the person ever been told that they have, or need assistance for, one of the following:

Intellectual Disability: No
Specific Learning Disabilities: No
Motor Skills Disorders: No
Communication Disorders: No
Autism Spectrum Disorder: No

Complete the following for all children and for adults with developmental disabilities:

During pregnancy did this person's mother:

Receive health care: No
Drink alcohol: No
Use tobacco: No
Use any illicit drugs: No
Use any medications: No
Have any medical or emotional problems: No
Give birth prematurely: Yes
Experience complications during labor/delivery: No

If yes to any of above, explain:

Premature birth. Mom had a c-section

Indicate below if the person ever experienced any of the following:

Could not gain weight: No
Wet the bed or soiled his/her clothes: No
Had difficulty with coordination: No
Had difficulty with speech: No
Had unusual sensitivity to touch: No
Had difficulty with social skills: No

Was evaluated for taking too much time to develop certain skills (e.g. communicating, reading, spelling, speech, language): No
Severe Illness: No

Education/Vocation

Client Name: Jeffrey Bodin
Date of Birth: 05/22/1997

Highest grade completed: High School Diploma/GED

Current Literacy Level: proficient

Are you currently involved in school or a vocational training program? No

Special Ed:

Are you currently employed? No

If NO, are you currently looking for work? No

Any barriers to obtaining employment?

Primary Source of Income: Family/Relative

Do you receive disability income? No

What kind?

Are you receiving any financial support or assistance from state or federal entitlement programs (i.e. TANF, child support, food stamps)?
None

Do you gamble? No

Have you ever felt the need to bet more and more money? No

Has anyone ever expressed concern over how much you gamble? No

Substance Use

Client Name: Jeffrey Bodin
Date of Birth: 05/22/1997

Complete the UNCOPE SCREENING for adults or the CRAFFT SCREENING for children:

SUBSTANCE RELATED DISORDERS- SCREENING FOR ADULTS

UNCOPE SCREENING (Age 18 and Above) (Hoffman, N.G. Retrieved from http://www.evinceassessment/UNCOPE_for_web.pdf)

1. **In the past year, have you ever drunk or used drugs more than you meant to? OR have you spent more time drinking or using than you intended to?**

2. **Have you ever neglected some of your usual responsibilities because of using alcohol or drugs?**

3. **Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?**

4. **Has anyone objected to your drinking or drug use? OR has your family, a friend, or anyone else ever told you they objected to your alcohol or drug use?**

5. **Have you ever found yourself preoccupied with wanting to use alcohol or drugs? OR have you found yourself thinking a lot about drinking or using?**

6. **Have you ever used alcohol or drugs to relieve emotional discomfort, such as sadness, anger, or boredom?**

(Two or more positive responses indicate possible abuse or dependence. Four or more positive responses strongly indicate dependence.)

COMPLETE the Standard Assessment Substance Use Table, if TWO OR MORE responses are YES.

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Legal Issues

Client Name: Jeffrey Bodin
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Legal history and involvement (custody/guardianship, arrests, probation, court-ordered treatment):
No

Mental Status

Client Name: Jeffrey Bodin
Date of Birth: 05/22/1997

Oriented: person, place, time, situation.
Appearance: clean.
Level of Consciousness: alert.
Eye Contact: good.
Concentration: good.
Motor Activity: normal.
Speech: normal.
Memory: immediate intact, short-term intact, long-term intact.
Affect: appropriate.
Mood: depressed.
Thought Process: logical.
Thought Content: grandiosity.
Hallucinations: none reported.
Judgment and Impulse Control: partial.
Insight: fair.

Risk Assessment

Client Name: Jeffrey Bodin
Date of Birth: 05/22/1997

Have you ever thought about harming yourself or someone else? 0

Have you ever harmed/injured yourself or someone else intentionally? 0

Does the person demonstrate symptoms that suggest a risk for DTS, withdrawal, seizures, overdose or toxic use that may require immediate interventions? No

In terms of other potential risk factors, does the person appear:

Malnourished: No
Dehydrated: No
Dirty/malodorous: No
At risk of exposure to the elements: No

Considering the responses to the above risk factors in combination with all the other information you know about the person (e.g., gender, age, diagnosis, balancing factors, resiliency and supports), would you rate the level of risk for this person as:

Risk of Harm to Self: Low Risk
Risk of Harm to Others: Low Risk

Please explain your rating:

Client denies any past or current SI/HI

Overall Impressions

Client Name: Jeffrey Bodin
Date of Birth: 05/22/1997

Overall Impressions: (Narrative)

The client is a 20 y/o Caucasian male who presented to this office as a referral from his parents. The client arrived on time and was appropriately dressed. He presented with an anxious mood and flat affect. The client reported that following presenting symptoms: Depression: sadness, isolation, fatigue, lack of motivation Anxiety: stress, racing thoughts. The client reported that his relationship with his mother is strained. He stated that she tries to irritate him. He stated that he is convinced that she has "mental health issues." The client denied any psychotic symptoms, however, the client did present with grandiosity and possibly paranoia. The parents reported that the client is "very paranoid" and is convinced that his parents "are out to get him." He reported that his parents steal his mail and invade his personal life. The client was diagnosed with cancer at the age of 10. He described how at the age of 12 he was diagnosed with Peripheral Neuropathy and Narcolepsy. The clent reported that when he is on a stimulant, like Adderall, he is able to function and be sociable. He stated that his mother took him off of his medications and now he struggles not to sleep 12 + hours a day. The client denies any substance abuse or legal issues. He reported that he did graduate high school but he did not make good grades because he was unable to attend regularly or spend time studying because he was always too tired. The client is not employed and lives with his mother, father and sister. Staff will need to further evaluate to discover if client is appropriate for EPIC program.

Treatment Recommendations:

Need	Disposition	Recommendations	Preferences
Depression/Anxiety	Address	Individual therapy and medication management (possible EPIC program)	Medication managment

Diagnostic Impressions

Axis I:	DSM -IV	ICD-10	DSM -V	Specifiers
.	ECB96329-D43D-4209-8D67-FF4AFA8B8A5D	F32.9	Unspecified depressive disorder	

Axis II: **Axis III:** NONE

Significant recent losses as of 10/31/2017:

Axis V: NONE

Headrick LPC, James
Provider

11/09/2017
Date

***For Behavioral Health Professional Signatures see ComAsmtAffidavit**

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Sinfonía Family Services of Louisiana

MRN #: 000000001984

Behavioral Health Service Plan

Name: Jeffrey Bodin **DOB:** 05/22/1997 **MRN:** 000000001984

Program: EPIC **Today's Date:** 11/9/2017

Axis I:	DSM -IV	ICD-10	DSM -V	Specifiers
.	ECB96329-D43D-4209-8D67-FF4AFA8B8A5D	F32.9	Unspecified depressive disorder	

Axis II: **Axis III:** NONE

Significant recent losses as of 10/31/2017:

Axis V: NONE

Individuals at Service Planning Meeting: client, clinician

Recovery Goal: to get my parents to leave me alone

Client/family say the following needs to have happened in order for them to feel ready to leave services: parents will support his needs and give him his privacy

Person's Strengths

Type	Strength	Evidenced By
Individual	I am resiliant	self

Objectives and Interventions

Type of Goal	Need	Objective	Services	Freq	Current Measure	Desired Measure	Target Date	Met	Achieved Measure
	Depression	To learn at least one new coping skill withtin a 3 month period to help alleviate depression symptoms.	CBT+ for Depression, Navigate (EPIC), Psychiatric Services	1 hour/week with Clinician	Depression: sadness, isolation, fatigue, lack of motivation	alleviation of symptoms.	02/10/2018		

	Anxiety	To learn at least one new coping skill within a 3 month period to help alleviate anxiety symptoms.	CBT+ for Anxiety, Psychiatric Services	1 hour/week with Clinician	Anxiety: stress, racing thoughts.	alleviation of symptoms.	02/10/2018		

Additional Services

Discharge Plan

Yes, client has received a copy of this plan: ☐
Client was offered a copy of this plan: ☒

◉ Yes, client participated in the development of this plan and agrees.

○ No, client participated in the development of this plan; however, client disagrees

Review Date (Objective Target Date): 11/09/2018

{SIGNATURE PAD} — 11/10/2017 08:11 AM
Patient Name — Date

{SIGNATURE PAD} — 11/10/2017 08:11 AM
Guardian Name — Date

Electronically Signed by: James Headrick LPC — 11/10/2017 08:11 AM
Provider Signature — Date

{SIGNATURE PAD} — 11/10/2017 08:11 AM
Signature — Date

{SIGNATURE PAD} — 11/10/2017 08:11 AM
Signature — Date

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***For Behavioral Health Professional Signatures see BHServicePlanAffidavit**