Date: 8/19/24

Client Name: AN

Parent(s)/Guardian Name(s) and contact information: XXXXXXX

List names and contact information of all parties with legal responsibility for making medical decisions for client (e.g. parent with joint custody): mom and dad

Is the client in foster care? No

If so, for what county?

What is the name and contact information of the social worker?

What is the name and contact information of the primary foster parent?

DOB: XXXX

Reasons for seeking treatment: "[AN] has been getting angry easily; she has an episode many times a day; she gets upset and screams and yells. Sometimes she wants to leave the house.

For how long has this occurred: It's gotten worse for the past few months

What types of treatments already tried: she used to be on more medication but it was changed. She takes medication but it might need to be changed

Has the client ever used mindfulness therapies? Please explain. No.

Would you be interested in looking into mind/body therapies (e.g. meditation, breathing, stretching with breath, yoga, etc.) for the current condition(s)? Yes, if it would help.

Primary Care Physician and contact information: Northbay Healthcare clinic, (707) 646-5500, Dr. Benko

Date of last physical exam: 7/2024

Past Medical History:

Does the client suffer from any medical conditions: seasonal allergies.

Does the client experience pain or tightness in any part of the body on a regular basis? No

Medications currently being used: aripiprazole 10mg at night, loratadine 10mg in the morning

Past surgical procedures: none

Does the client participate in any exercise currently? If so, what types? No; she walks outside sometimes

Past Psychiatric History:

Past psychiatric hospitalizations, dates, and reasons for hospitalization: no hospital stays.

Number of suicide attempts: none

Date of last suicide attempt: n/a

Have you seen a psychiatrist in the past? Yes, at Turning Point Clinic.

Contact information of past psychiatrist(s): he left

Past psychiatric medications and effects or side effects: she has not tried other psychiatric medications.

Family History:

Does anyone in the family suffer from any mental health conditions? If so, who and what conditions have they been diagnosed with? No.

Social History:

With whom does the client live? Mom and dad

School Name: no longer in school

Current grade level: graduated high school

Grades at school: As, Bs, Cs.

Has the client ever failed a school grade? No

Has the client taken special education classes? No

Does the client have an Individualized Education Plan or 504 Plan? No

For what condition(s)? N/a

Does the client currently have difficulties with socialization? She has friends but since she got sick, she does not spend much time with them.

Social or cyber bullying? No

Developmental History:

Did mother suffer from any medical conditions during pregnancy? No

Did mother take prenatal vitamins during pregnancy? No

Did mother consume any drugs or alcohol during pregnancy? No

Was client born via vaginal delivery or C section? Vaginal delivery

Were there any complications during the delivery? No

Did the client have to remain in the hospital after birth for any reason and why? No

Did the client cross developmental milestones on time? (e.g. walk on time, speak on time, toileting self on time) yes

Is there any additional information you would like to share with the doctor? AN used to be able to go to school on her own and had friends.