Date: 8/4/24

Client Name: YVM

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): biological mom only; father does not have custody

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: "[YVM] has had trouble going to school because she doesn't sleep well at night. She is really anxious in the daytime."

For how long has this occurred: Years

What types of treatments already tried: she is in therapy and exercises by walking around basketball court in park close to her house.

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

Primary Care Physician and contact information: Fairfield Pediatric Primary Care, (707) 784-2010

Date of last physical exam: 6/2024, before school

Past Medical History:

Does the client suffer from any medical conditions: obesity, high cholesterol; had normal labs including thyroid labs in Jan 2024

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

Medications currently being used: none

Past surgical procedures: none

Does the client participate in any exercise currently? If so, what types? Yes, she walks in the park around the court

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? No.

Contact information of past psychiatrist(s): n/a

Past psychiatric medications and effects or side effects: none

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? Biological mom, maternal grandfather, younger brother and younger sister. They don't get along well.

School Name: Fairfield High School

Current grade level: 10th

Grades at school: Bs, Cs, Ds.

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? Yes, for anxiety

For what condition(s)? Anxiety disorder

Does the client currently have difficulties with socialization? She gets anxious in groups of people

Social or cyber bullying? No

Developmental History:

Did mother suffer from any medical conditions during pregnancy? No

Did mother take prenatal vitamins during pregnancy? Yes

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, except she was 2 weeks late

Did the client have to remain in the hospital after birth for any reason and why? No, but she had ear infections in infancy

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? No