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## 2. MEDIUM-LOW SEVERITY CASE
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**MH-29845-DOC**
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### # MAX SUPER SPECIALITY HOSPITAL

Department of Psychiatry and Mental Health

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**Patient ID:** MH-29845
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#### ## ASSESSMENT SUMMARY

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**Emergency Contact:** Armaan Rawat - +91 9876123456
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Sonalika presented for her scheduled follow-up appointment reporting mild to moderate mood fluctuations with occasional anxiety symptoms. She describes improved sleep quality with medication and generally stable energy levels. Her self-reported questionnaire data indicates mild

<sup>\*\*</sup>Name:\*\* Sonalika Rawat

<sup>\*\*</sup>DOB:\*\* 15/09/1988 (36 years)

<sup>\*\*</sup>Gender:\*\* Female

<sup>\*\*</sup>Contact:\*\* +91 9876543210

<sup>\*\*</sup>Primary Care Physician:\*\* Dr. Anil Sharma

<sup>\*\*</sup>Insurance:\*\* ICICI Prudential, #HP78392015

<sup>\*\*</sup>Date of Assessment:\*\* 8 April, 2025

<sup>\*\*</sup>Clinician:\*\* Dr. Priya Malhotra, MD, Psychiatry

anxiety with occasional dips in mood. Patient denies any self-harm ideation and reports gradual improvement since beginning treatment.

## KEY MENTAL HEALTH PARAMETERS

### MENTAL HEALTH INDICATORS

Parameter   Score/Rating   Clinical Notes
Mood   6/10   Mild low mood episodes, generally stable
Anxiety   Mild   Occasional worry, primarily situational
Sleep Quality   7/10   Generally restorative sleep with rare disruption
Energy Levels   6/10   Adequate for most daily activities
Physical Symptoms   Minimal   Occasional tension headaches only
Concentration   7/10   Mostly intact, occasional mild distraction
Self-Care   8/10   Maintaining regular hygiene and self-care routine
Interests   7/10   Re-engaging with most previously enjoyed activities
Intrusive Thoughts   2/10   Infrequent worry thoughts, easily redirected
Optimism   7/10   Generally positive outlook with realistic goals
Social Support   8/10   Good family support, reconnecting with friends
Self-Harm Risk   None   No thoughts of self-harm reported

## ### ADDITIONAL CLINICAL DATA

# \*\*Stress Factors:\*\*

Patient identifies occasional work deadlines as mild stressors. Reports improved coping with work demands and better boundaries. Financial situation stable. Home environment described as supportive and harmonious.

## \*\*Coping Strategies:\*\*

Patient reports consistent application of breathing exercises (4-5 times weekly). Regular evening walks (5 times weekly). Resumed journaling practice with positive effect. Minimal alcohol use limited to social occasions only.

\*\*Discussion About Professional Support:\*\*

Patient expresses satisfaction with current medication regimen and therapy frequency. Interested in transitioning to monthly maintenance therapy sessions. Has successfully implemented workplace accommodations with positive outcome.

#### ## ASSESSMENT & RECOMMENDATIONS

### \*\*Clinical Impression\*\*

Patient presents with symptoms consistent with Mild Major Depressive Disorder (F33.0), in partial remission. Current PHQ-9 score of 8 indicates mild depression. GAD-7 score of 6 indicates mild anxiety. Significant improvement noted since treatment initiation.

- \*\*Treatment Recommendations\*\*
- Continue Escitalopram 10mg daily
- Transition to monthly therapy sessions
- Maintain current coping strategies
- Consider gradual return to full work responsibilities
- Continue social reintegration activities
- Maintain sleep hygiene practices

### \*\*Safety Plan\*\*

No active safety concerns identified. Patient aware of crisis resources should symptoms worsen. Preventative self-care plan in place for stress management.

## ## FOLLOW-UP PLAN

- \*\*Next Appointment:\*\* 8 May, 2025 at 10:30 AM
- \*\*Medication Review:\*\* At next appointment
- \*\*PHQ-9/GAD-7 Reassessment:\*\* Monthly
- \*\*Care Coordination:\*\* Routine update to PCP at patient's next physical
- \*Electronically Signed:\*

