
Patient History: Mental Illness

Patient ID: 001234
Date of Birth: 02/15/1993
Age: 32
Gender: Male
Date of Admission: 02/17/2025

Chief Complaint:
The patient reports experiencing ongoing feelings of sadness, fatigue, and a lack of interest in everyday activities for the past six months. He states that he often feels overwhelmed by stress and has difficulty maintaining focus on work. His sleep pattern is disturbed, with frequent waking throughout the night.

History of Present Illness:
The patient, a 32-year-old male, reports a gradual onset of depressive symptoms over the last six months. He attributes these feelings to increased work pressure and unresolved personal issues. He denies any history of psychiatric illness but acknowledges that he has been under stress since a major job transition. The patient describes feeling hopeless, frequently thinking that his efforts in both personal and professional life are futile.

He states that his motivation has decreased significantly, and he struggles to complete tasks he once found enjoyable. His energy levels are low, and he feels exhausted even after a full night's rest. He has also noticed a marked decrease in his social interactions, avoiding friends and family. Additionally, the patient has expressed feelings of guilt and self-blame, especially regarding his inability to meet expectations.

The patient reports having trouble concentrating at work, often feeling distracted and unable to meet deadlines. These difficulties at work have led to increased anxiety. He is also experiencing physical symptoms, such as headaches and muscle tension. He has had no previous psychiatric consultations.

Past Medical History:

- **Medical Conditions**: The patient has a history of chronic lower back pain for which he takes over-the-counter pain medications. There are no other major medical conditions reported.
- **Surgeries**: No surgical history.
- **Allergies**: No known drug allergies.
- **Medications**: The patient currently takes ibuprofen for back pain, with no psychiatric medications.

- **Family History**: There is a history of mental health disorders in the family. The patient's mother has been diagnosed with depression, and his maternal aunt has a history of generalized anxiety disorder.

Psychiatric History:
This is the patient's first psychiatric consultation. He reports no previous history of mental health issues, such as anxiety or depression, prior to the current episode. He denies any history of self-harm, suicidal thoughts, or psychosis. The patient was never hospitalized for psychiatric reasons and has not undergone any therapy or counseling.

Social History:

- **Occupation**: The patient works as a software engineer at a tech company, where he reports a high level of stress and long working hours.
- **Substance Use**: The patient denies alcohol or drug use. He does not smoke.
- **Social Support**: The patient lives alone in an apartment. While he has close friends, he reports that he has become increasingly isolated and avoids socializing. He maintains occasional contact with his family, although he feels distant and disconnected from them.
- **Lifestyle**: The patient reports a sedentary lifestyle, with minimal physical activity. He often feels too tired to exercise and spends most of his free time either at work or engaging in passive activities like watching TV.

Mental Status Examination:

- **Appearance**: The patient is appropriately dressed for the weather, but his posture is slouched, and he appears fatigued.
- **Mood and Affect**: The patient's mood is described as "down," with a congruent affect. His speech is slow, and his tone is flat. He reports feelings of sadness, hopelessness, and frustration.
- **Thought Process**: The patient’s thought process is coherent, but there are indications of ruminative thoughts, often focused on his perceived failures and personal shortcomings.
- **Cognition**: The patient is fully oriented to time, place, and person. His concentration is somewhat impaired, as he had difficulty focusing during the interview.
- **Insight and Judgment**: The patient demonstrates fair insight into his symptoms and acknowledges the impact they have on his daily life. His judgment appears intact.
- **Risk Assessment**: The patient denies any current suicidal ideation or thoughts of self-harm. There are no indications of psychosis.

Diagnosis:

- **Primary Diagnosis**: Major Depressive Disorder (Moderate), as per DSM-5 criteria.
- **Secondary Diagnosis**: Generalized Anxiety Disorder, as the patient experiences persistent anxiety and worry, especially in relation to work and personal life.

Plan:

1. **Psychotherapy**: Recommend starting Cognitive Behavioral Therapy (CBT) to address negative thought patterns and provide coping strategies for stress and anxiety.
2. **Medication**: Consider starting an SSRI (Selective Serotonin Reuptake Inhibitor), such as sertraline, to help manage depressive and anxiety symptoms.
3. **Lifestyle Modifications**: Encourage regular physical activity, such as walking or swimming, to improve mood and energy levels. Recommend the patient start practicing relaxation techniques, such as deep breathing or meditation, to reduce anxiety.
4. **Follow-up**: Schedule a follow-up appointment in two weeks to evaluate progress and adjust treatment as necessary.

Summary:
This 32-year-old male presents with moderate depressive symptoms, with a history of increased stress, low motivation, social withdrawal, and physical symptoms such as fatigue and headaches. Family history of mental illness and the lack of prior psychiatric care may have contributed to the current condition. Treatment will include psychotherapy, medication, and lifestyle changes aimed at improving both psychological and physical well-being.