Patient Name: **Amieva, Yessenia**
MRN: 5293210000001 Sex/DOB/Age: Female 5/19/1998 25 years
DOD ID (EDIPI): 1548801377 Veterans ID (ICN):

Encounter Summary

Arrive Date	Discharge Date	FIN	MRN	Diagnosis	Client
3/10/2023	3/10/2023	54066629	5293210000001		0057C-Irwin Army Community Hospital
2/27/2023	2/27/2023	52893072	5293210000001		0057C-Irwin Army Community Hospital
11/24/2021	11/24/2021	19994637	5293210000001	; Other specified counseling	0057C-Irwin Army Community Hospital
	7/13/2023	68987141	5293210000001	Encounter for other administrative examinations	0057C-Irwin Army Community Hospital
	2/10/2023	51826600	5293210000001	Postpartum depression	0057C-Irwin Army Community Hospital
	2/3/2023	50584882	5293210000001	Anxiety disorder, unspecified; Depression, unspecified	0057C-Irwin Army Community Hospital

Office and Clinic Notes

Document Type: Mental Health Outpt Note
Service Date/Time: 7/13/2023 15:34 CDT
Result Status: Auth (Verified)
Perform Information: GOODMAN,CLARA H (7/13/2023 15:36 CDT)
Sign Information: SOBERING,KRISTINE K,LCSW (7/13/2023 15:42 CDT); GOODMAN,CLARA H (7/13/2023 15:36 CDT)

Behavioral Health
BH Clearing: 13 July 2023

High Interest
High Interest: No

Special Duty
No Special Duty Status Indicated.

BHDP Data
BHDP/MHS GENESIS Note

Provider Reviewed and Discussed with Patient: The patient completed questionnaire(s) containing relevant history and measures detailing current symptomatology utilizing the Behavioral Health Data Portal (BHDP) screeners. Provider reviewed responses and progress in implementing the treatment discussed in the above treatment section of this report. The patient's self-report has been reviewed in detail by this provider and all relevant elements were reviewed with the patient. A summary of the patient's self-report as follows:

Brief Emotional/Behavioral Assessment Interpretations:
PHQ-9: 0-4 =Minimal Depression; 5-9= Mild Depression; 10-14 =Moderate Depression; 15-19= Moderate-Severe Depression; 20-27 =Severe Dep
GAD-7: 1-4 =Mild Anxiety; 5-9 =Moderate Anxiety; 10-14 =Moderately Severe Anxiety; 15-21 =Severe Anxiety
PCL–5: No PTSD/ subthreshold: PTSD < 33. Probable PTSD > 33.
ISI: 0-7 =No significant insomnia; 8-14 =Subthreshold insomnia; 15-21 =Moderate severity clinical insomnia; 22-28 =Severe clinical insomnia

Measurement Results

Measure	Baseline/ First Score	Previous Score	Most Recent Score	Most Recent Score Interpretation	Most Recent Date
AUDIT-C Alcohol Use Disorders Screener	1		1	Based on clinical assessment, brief alcohol counseling in primary care may be considered (e.g., medication interaction, safety concerns).	13Jul2023
BASIS-24 **Emotional Lability Subscale** General Distress	2.89			High Level of Distress	03Feb2023
BASIS-24 **Psychosis Subscale** General Distress	0			Subclinical to Low Level of Distress	03Feb2023
BASIS-24 **Relationships Subscale** General Distress	0.1		0	Subclinical to Low Level of Distress	13Jul2023
C-SSRS-S Lifetime Screener	**Green**			No Follow-up Indicated.	03Feb2023

Problem List/Past Medical History
Ongoing
- Ankle pain
- Anxiety disorder, unspecified
- Cholelithiasis
- Depression, unspecified
- Diastasis recti
- Encounter for other administrative examinations
- Hirsutism
- Missed miscarriage
- Pain in right knee
- Pain of knee region
- Pain of right ankle joint
- Pelvic and perineal pain
- Postpartum depression
- Pregnant

Historical
- Bells palsy of left side of face
- Childbirth education done
- Normal pregnancy in primigravida
- Other specified counseling
- Pregnant
- Pregnant
- Vaginal granulation tissue

Procedure/Surgical History
- Cholecystectomy Laparoscopy (No Laterality) (09/15/2022)

Medications
PNV Prenatal oral tablet, 1 tab(s), Oral, Daily, 3 refills
Refresh Plus ophthalmic solution, 1 drop(s), Eye-Both, every 2 hr, PRN, 6 refills
Refresh Plus ophthalmic solution, 1 drop(s), Eye-Both, TID, PRN, 11 refills

Allergies
No Known Allergies

Social History
Alcohol
Never Use:., 02/03/2023
E-Cigarette/Vaping
Never - E-Cigarette/Vaping user Electronic Cigarette Use:., 09/02/2022

Office and Clinic Notes

Suicide Risk					
C-SSRS-S Past Month Suicide Risk	**Green**	**Green**	**Green**	No Follow-up Indicated.	13Jul2023
CSI Couples Satisfaction Index	5		1	Significant Relationship Distress Reported. Evaluation Indicated.	13Jul2023
WRAIR + Social Impairment **Personal or Social/Occupational/Leisure (subscales)** Functional Impairment	781/1554/1	2/0/1	6/1554/1		13Jul2023
GAD7 Anxiety Screener	7	5	8	No Anxiety Syndrome Detected.	13Jul2023
ISI Insomnia Symptoms	3	7	5	No Clinically Significant Insomnia.	13Jul2023
K6 General Distress	10		8	Moderate Distress.	13Jul2023
Pain Physical Pain Rating	2	0	0		13Jul2023
PHQ9 Depression Symptoms	6	8	11	Minor Depressive Symptoms Reported.	13Jul2023
TBI Screen Traumatic Brain Injury	**Negative**			Negative on TBI Screen.	03Feb2023
Therapeutic Alliance Patient/Provider Relationship	-3		18		13Jul2023

Informed Consent
Reviewed limits of confidentiality prior to initial encounter; patient expressed understanding and agreed to proceed
Informed Consent Discussed and Given: Yes

Chief Complaint
clearing ets

History of Present Illness/Subjective
13 July 2023 - 25 y/o, female, ADSM, TIS 4 y/r, clearing date is 01 Aug 2023.
SM was provided with the information & contact numbers for the Army's In-Transition Program and explained how their services can be useful to her in the future.
SM is looking forward to being a stay-at-home mother. SM had joined the Army to gain training in the area of IT work and look toward working for the FBI in the future. SM now wants to focus on raising her 1 ½ y/o daughter.
SM requested a list of Behavioral Health Providers who accept TriCare (her spouse is retired Army).
SM will be staying in Salina, Ks where they have been living once she was stationed at Ft Riley. SM spouse was enrolled in the aviation school in Salina, KS and has now switched his focus to welding.

Current Session
Topics Discussed During Visit: Coping with life circumstances, Family issues, Parenting
Therapeutic Interventions: CBT, Interpersonal
Patient Participated and Benefited: Yes
Time Spent: 30 minutes
Psychotherapy Start time: 14:15
Psychotherapy Stop time: 14:45
Current Session Review: Clearing

Employment/School
Work/School description: Active duty. Highest education level: University degree(s)., 05/06/2021
Exercise
Physical Activity Consultation: Counseled to maintain physical activity., 05/06/2021
Home/Environment
Lives with Spouse. Marital Status of Patient if Patient Independent Adult: Married. Spouse Name: Joshua Journet. Living situation: Home/Independent. Feels unsafe at home: No., 05/06/2021
Nutrition/Health
Diet: Regular., 05/06/2021
Sexual Orientation and Gender Identification (SOGI)
Sexually active: Yes. Sexual orientation: Straight or heterosexual. What is your current gender identity? (Check all that apply) Identifies as female. History of sexual abuse: No., 05/06/2021
Substance Use
Never Use:., 11/30/2022
Tobacco
Frequent/Daily exposure to secondhand smoke in indoor/confined spaces No. Never-cigarette user Cigarette use:. Never-other tobacco user (not cigarettes) Other Tobacco use:., 04/18/2023

Family History
Breast cancer: Paternal Grandmother - FH.
Cancer: Paternal Grandmother - FH.
Heart attack: Maternal Grandmother - FH.
Hypertension: Paternal Grandmother - FH.

Office and Clinic Notes

Pain
DVPRS Pain Scale: 4 - Distracts me, can do usual activities
Primary Pain Location: Back
Pain Follow Up: Pain is being addressed

Medication Side Effects
Current Medications:
- What medications and supplements are you taking? NONE
- Are you taking your medication(s) as prescribed? N/A
- Are you experiencing benefit from the medication(s)? N/A
- What side effects or adverse drug reactions, if any, are you experiencing from the medications? N/A

Pertinent Collateral Information
Command Contact: CPT Nathan Anderson (07/13/23 14:36:00)
Pertinent Collateral Information: 786-201-7037 (07/13/23 14:36:00)
Referral Source: Self (07/13/23 14:36:00)
Unit and Phone Number: HSC, HHBN7125794162 (07/13/23 14:36:00)

Objective

MSE
Mood: Other: Neutral
Thought Process: Intact
Appearance.: Appropriately dressed and groomed
Speech: Normal
Affect: Full
Thought Content.: Non-psychotic
Insight.: Fair
Judgment: Fair

Past Psychiatric History
Prior Behavioral Health Care: No
Prior Behavioral Health Care Comments: SM DENIED.
Prior Medication Treatment: No
Prior Medication Treatment: SM DENIED.
Prior Suicide Attempts: No
Prior Suicide Attempts: SM DENIED.
History of Other Self Harm Behaviors: No
History of Other Self Harm Behaviors: SM DENIED.
Harm to Others/Violent Behavior: No
Prior Harm to Others/Violent Behavior: SM DENIED.
Additional Treatment Comments: No additional treatment comments.

Trauma, Abuse and Patient Safety
Physical Abuse: No
Physical Abuse Comments: SM DENIED.
Emotional Abuse: No
Emotional Abuse Comments: SM DENIED.
Forced Sexual Activity: No
Sexual Abuse Comments: SM DENIED.
Experienced Neglect: No
Neglect Comment: SM DENIED.
Experienced Exploitation: No
Experienced Exploitation Comments: SM DENIED.
Does Patient Feel Safe at Home: Yes

Office and Clinic Notes

Other Traumatic Event: No
Other Trauma Comments: SM DENIED.

Military Trauma
Military Service-Related Trauma: No
Military Service Trauma Comments: SM DENIED.

Risk Assessment

***** Summary of Safety Assessment:**
In determining current acute risk levels for suicide/homicide, provider reviewed risk and protective factors and history of suicidal and self-injurious behavior. The patient is released without limitations, verbally commits to the plan below and current safety to self/others and is deemed appropriate for continued outpatient care. Patient was instructed in how to seek emergency care if safety issues arise, including dangerous reactions to medications.

It is common medical knowledge that there is no reliable way to predict who will ultimately die by suicide. The majority of psychiatry patients have multiple suicide risk factors; however, the majority of psych patients do not die by suicide. Stable chronic risk factors are usually not a reason for admission and acute stressors must be considered in the context of the patient's presentation to determine the appropriate treatment level. Therefore, the risk factors are to be considered in the context of the entire evaluation of the patient and in the context of their specific circumstances. Patients are capable of providing or withholding information as desired. Safety plan was reviewed with the patient as needed.

Access to Weapons: Yes
Access to Weapons Detail: Husband has 1 pistol for home defense; it is stored in the top of a closet in a lockbox.
Warning Signs- BH: Agitation, Anger, Anxiety, Feeling trapped, Mood change
Protective Factors- BH: Adequate medical/mental health support, Financial stability, Good impulse control, Help seeking, Intact marriage, Safe and stable environment
General Risk Factors- BH: Access to firearms or other lethal means, Relationship problems/break-up

Suicide Risk Level
Is the Patient at Risk: No, risk not detected
Acute Suicide Risk CSRE: Low
Chronic Suicide Risk CSRE: Low
Morbid Ideation: Denies
Suicidal Ideation: Denies
Suicide Method: Denies
Suicide Plan Created: Denies
Suicide Intent: Denies
Suicide Attempt: Denies
Suicide Risk Details: NO SUICIDE RISK DETECTED

Homicide Risk Level
Violence Risk Assessed As: Not Detected
Assault Ideation: Denies
Homicide Ideation: None
Recent Homicide or Assault Attempt: Denies
Violence Risk Details: NO VIOLENCE RISK DETECTED

Office and Clinic Notes

Coping and Safety Plan Safety Plan Reviewed with Patient: Not clinically indicated

Assessment and Treatment Plan

Formulation
13 July 2023 - 25 y/o, female, ADSM, TIS 4 y/r, clearing date is 01 Aug 2023.
SM was provided with the information & contact numbers for the Army's In-Transition Program and explained how their services can be useful to her in the future.
SM is looking forward to being a stay-at-home mother. SM had joined the Army to gain training in the area of IT work and look toward working for the FBI in the future. SM now wants to focus on raising her 1 ½ y/o daughter.
SM requested a list of Behavioral Health Providers who accept TriCare (her spouse is retired Army).
SM will be staying in Salina, Ks where they have been living once she was stationed at Ft Riley. SM spouse was enrolled in the aviation school in Salina, KS and has now switched his focus to welding.

Diagnosis
1. Encounter for other administrative examinations
Diagnosis: **1**. Encounter for other administrative examinations
Comment:
Other status: Psychotherapy Patient +/ Family 30 minutes 90832; 07/13/2023 14:15:00 CDT (Completed)
Emot/Behavl Assess w/Score & Doc; per tool 96127; 07/13/2023 14:15:00 CDT, PHQ9; CSI, 2 (Completed)

End of Orders

Prognosis
Prognosis: Good

General Treatment Planning
Benefits, Risks, Alternatives Discussed: Yes
Treatment Plan: Encourage balanced diet, Exercise 4-5 times / week, Practice good sleep hygiene, Referral to individual, family or group therapy, Other: Referral to off-post marital therapy per Teri Nelsen.
Number of Visits Expected: 4-8
Target Symptoms: Anxiety, Depression, Relationship issues
Goals of Treatment: Improve overall functioning, Decrease in target symptoms
Methods of Monitoring Outcomes: Other: Reduced BASIS-24 (emotional lability) and K6 (general distress)
Evaluation Type: By complexity
Objectives of Treatment #1: reduce bereavement, sadness symptoms and anxiety symptoms
Goals of Treatment #1: Decrease in target symptoms
Interventions of Treatment #1: CBT; Interpersonal therapy
Objective #1 Goal Status: Initial
Objective #1 Start Date: 02/10/23
Objective #1 Date Met: 07/13/23
Objective #1 Comment: intake
Treatment Planning Requirements: 1) Developed treatment plan collaboratively with patient, with agreement on plan of care and goals, 2) Patient agrees to attend appointments, engage in treatment, discuss any concerns in order to meet treatment goals, 3) Provider will leverage patient strengths and limit potential barriers to treatment

Office and Clinic Notes

Disposition
Disposition
Psychologically fit for full duty: Yes
Command Consultation: No
Issued Profile/DLC/LIMDU: No
Able to Carry and Fire a Weapon: Yes
BH Able to Deploy: Yes
Change in Special Duty: No
Change in Security Clearance: No
MEB Referral/In Progress: No
Admin Separation Referral/In Progress: No
Disposition Comment: RETURN TO DUTY-- CLEARED BY BH FOR ETS ON 13 JULY 2023

This medical record entry was completed using the Military Health System (MHS) GENESIS system. Format and structure of this entry is dictated by MHS GENESIS. Additional information from this encounter can be found with its associated Form. Record entries that include "No qualifying data available" reference information that may be recorded in this encounter's associated form.

(Clara) Hope Goodman
Social Services Assistant
Outpatient Behavioral Health Clinic
Irwin Army Community Hospital
Fort Riley, KS

This provider staffed and discussed patient with Hope Goodman, SSA. Direct supervision was immediately available. This provider assessed for safety and no noted active or current SI/HI/HAL/DEL.

KRISTINE SOBERING, CIV, ARMY, LSCSW, LCAC, MAC
BEHAVIORAL HEALTH CLINICAL SOCIAL WORKER
IACH OUTPATIENT BEHAVIORAL HEALTH CLINIC
IRWIN ARMY COMMUNITY HOSPITAL
FORT RILEY, KANSAS

Electronically Signed on: 07/13/2023 15:36 CDT

GOODMAN, CLARA H

Electronically Signed on: 07/13/2023 15:42 CDT

SOBERING, KRISTINE K, LCSW

Document Type: Mental Health Outpt Note
Service Date/Time: 2/10/2023 09:00 CST
Result Status: Auth (Verified)
Perform Information: SOBERING,KRISTINE K,LCSW (2/10/2023 11:18 CST)
Sign Information: SOBERING,KRISTINE K,LCSW (2/10/2023 11:18 CST)

Office and Clinic Notes

Behavioral Health
Follow-up #1: 10 February 2023

High Interest
High Interest: No

Special Duty
None

BHDP Data
BHDP/MHS GENESIS Note

Provider Reviewed and Discussed with Patient: The patient completed questionnaire(s) containing relevant history and measures detailing current symptomatology utilizing the Behavioral Health Data Portal (BHDP) screeners. Provider reviewed responses and progress in implementing the treatment discussed in the above treatment section of this report. The patient's self-report has been reviewed in detail by this provider and all relevant elements were reviewed with the patient. A summary of the patient's self-report as follows:

Brief Emotional/Behavioral Assessment Interpretations:
PHQ-9: 0-4 =Minimal Depression; 5-9= Mild Depression; 10-14 =Moderate Depression; 15-19= Moderate-Severe Depression; 20-27 =Severe Dep
GAD-7: 1-4 =Mild Anxiety; 5-9 =Moderate Anxiety; 10-14 =Moderately Severe Anxiety; 15-21 =Severe Anxiety
PCL–5: No PTSD/ subthreshold: PTSD < 33. Probable PTSD > 33.
ISI: 0-7 =No significant insomnia; 8-14 =Subthreshold insomnia; 15-21 =Moderate severity clinical insomnia; 22-28 =Severe clinical insomnia

Measurement Results

Measure	Baseline/ First Score	Previous Score	Most Recent Score	Most Recent Score Interpretation	Most Recent Date
AUDIT-C Alcohol Use Disorders Screener	1			Based on clinical assessment, brief alcohol counseling in primary care may be considered (e.g., medication interaction, safety concerns).	03Feb2023
BASIS-24 Emotional Lability Subscale General Distress	2.89			High Level of Distress	03Feb2023
BASIS-24 Psychosis Subscale General Distress	0			Subclinical to Low Level of Distress	03Feb2023
BASIS-24 Relationships Subscale General Distress	0.1			Subclinical to Low Level of Distress	03Feb2023
C-SSRS-S Lifetime Screener Suicide Risk	**Green**			No Follow-up Indicated.	03Feb2023

Problem List/Past Medical History
Ongoing
- Ankle pain
- Anxiety disorder, unspecified
- Cholelithiasis
- Depression, unspecified
- Diastasis recti
- Hirsutism
- Missed miscarriage
- Pain in right knee
- Pain of knee region
- Pain of right ankle joint
- Pelvic and perineal pain
- Postpartum depression

Historical
- Bells palsy of left side of face
- Childbirth education done
- Normal pregnancy in primigravida
- Other specified counseling
- Pregnant
- Pregnant
- Vaginal granulation tissue

Procedure/Surgical History
- Cholecystectomy Laparoscopy (No Laterality) (09/15/2022)

Medications
Loestrin 21 1/20 oral tablet, 1 tab(s), Oral, Daily, 3 refills
Refresh Plus ophthalmic solution, 1 drop(s), Eye-Both, every 2 hr, PRN, 6 refills

Allergies
No Known Allergies

Social History
Alcohol
Never Use:., 02/03/2023
E-Cigarette/Vaping
Never - E-Cigarette/Vaping user Electronic Cigarette Use:., 09/02/2022
Employment/School
Work/School description: Active duty. Highest education level: University degree(s)., 05/06/2021
Exercise
Physical Activity Consultation: Counseled to maintain physical activity., 05/06/2021
Home/Environment
Lives with Spouse. Marital Status of Patient if Patient Independent Adult: Married. Spouse Name: Joshua Journet. Living situation: Home/Independent. Feels unsafe at home: No., 05/06/2021

Office and Clinic Notes

C-SSRS-S Past Month Suicide Risk	**Green**	**Green**	**Green**	No Follow-up Indicated.	10Feb2023
CSI Couples Satisfaction Index	5			Some Likely Relationship Distress Reported. Evaluation Indicated.	03Feb2023
WRAIR + Social Impairment **Personal or Social/Occupational/Leisure (subscales)** Functional Impairment	781/1554/1		2/0/1		10Feb2023
GAD7 Anxiety Screener	7		5	No Anxiety Syndrome Detected.	10Feb2023
ISI Insomnia Symptoms	3		7	No Clinically Significant Insomnia.	10Feb2023
K6 General Distress	10			Moderate Distress.	03Feb2023
Pain Physical Pain Rating	2		0		10Feb2023
PHQ9 Depression Symptoms	6		8	No Depressive Syndrome Detected.	10Feb2023
TBI Screen Traumatic Brain Injury	**Negative**			Negative on TBI Screen.	03Feb2023
Therapeutic Alliance Patient/Provider Relationship	-3			This section was started but patient reports not being seen in this clinic previously - no score.	10Feb2023

Nutrition/Health
Diet: Regular., 05/06/2021
Sexual Orientation and Gender Identification (SOGI)
Sexually active: Yes. Sexual orientation: Straight or heterosexual. What is your current gender identity? (Check all that apply) Identifies as female. History of sexual abuse: No., 05/06/2021
Substance Use
Never Use:., 11/30/2022
Tobacco
Exposure to Secondhand Smoke: No.
Never-cigarette user Cigarette use:.
Never-other tobacco user (not cigarettes)
Other Tobacco use:., 12/20/2022
Never-cigarette user Cigarette use:.
Never-other tobacco user (not cigarettes)
Other Tobacco use:., 12/12/2022

Family History
Breast cancer: Paternal Grandmother - FH.
Cancer: Paternal Grandmother - FH.
Heart attack: Maternal Grandmother - FH.
Hypertension: Paternal Grandmother - FH.

Informed Consent
Reviewed limits of confidentiality prior to initial encounter; patient expressed understanding and agreed to proceed
Informed Consent Discussed and Given: Yes

Chief Complaint
grief and anxiety symptoms following perinatal loss

History of Present Illness/Subjective

	Yes	No
Patient confirmed s/he attended this session voluntarily?	x	
Visit is deployment-related?		x
Visit is accident-related?		x
Has the patient had an unexplained fall in the last 3 months?		x
If Yes, was that fall due to tripping over an obstacle?		
Does the patient feel abused, neglected or exploited at home?		x
If Yes, by whom and how often?		

Office and Clinic Notes

This visit was completed in the IACH Multi-D Clinic. Spent 60 minutes with the patient discussing behavioral health concerns.

History of Presenting Issue (HPI): Pt reported experiencing situational anxiety. One situation that triggers anxiety is when she is driving and loses phone signal. She will become fidgety, her heart will race, she will struggle to catch her breath, and she will become pale. This will last for several minutes and then spontaneously resolve. During that time, she will worry about what would happen if she had a medical problem and could not contact anyone or got into an accident. She also may be at home (not necessarily alone) and will experience an anxiety attack for no apparent reason. The anxiety began about 2 years ago and has no identifiable trigger aside from it being the first time that she began driving long distances by herself. Her anxiety may occur daily and has not occurred for as long as one month. The pt never has gone to the ER for an anxiety attack. She reported that her paternal grandmother has anxiety, and she believes that she takes medication for it.

The pt reported that her depressive symptoms began around August 2022. She experienced an "overwhelming sadness" during which she did not want to do anything. The first episode lasted about one week. Subsequent episodes occurred 1-2 times per week and lasted 1-2 days. She felt better during the day when she spent time with her daughter and overcome with sadness after she put her daughter to bed. The patient denied symptoms of hypomania and mania. She described her depression over the last couple of weeks as undulating between depression and feeling normal. Her paternal grandmother also has depression.

The pt denied ever taking any OTC or prescription medication for anxiety or depression.

S: *This is what transpired in session.* SM attended first individual Behavioral Health follow-up appointment with, and first time meeting, this Provider and presented on time. Provider reviewed her understanding about SM's concerns as documented by Dr. Prewitt in her intake. SM shared that, right now, her primary concern is her sadness and loss, and sense of "it was my fault" following the recent death of the baby boy she was carrying at around 17 weeks gestation. SM shared about the surprise or learning she was pregnant (then joy), and have the concern about her spotting and continuing to come back to the hospital to inquire whether everything was okay. After being cleared to do pregnancy PT, she began to heavily hemorrhage after the first PT session, and continuing to bleed until they "lost the fetal heartbeat." She said she had to go to KU Med to deliver and described her sadness as she was in labor for several hours. SM has another daughter who is about 14 months old, and she is resigning her commission so that she and her husband can move away, and she will be able to spend more time with her daughter. We invested the bulk of this appointment processing SM's grief, building rapport and laying the foundation for the therapeutic relationship. We have follow-up appointments scheduled in 2 and 4 weeks.

Current Medications:
- What medications and supplements are you taking? birth control pills
- Are you taking your medication(s) as prescribed? YES
- Are you experiencing benefit from the medication(s)? YES

Office and Clinic Notes

- What side effects or adverse drug reactions, if any, are you experiencing from the medications? NONE IDENTIFIED AT THIS TIME.

Current Session
Topics Discussed During Visit: Managing anxiety, Coping with life circumstances, Family issues, Other: grief and loss
Doc of Therapeutic Interventions: CBT, Interpersonal
Patient Participated and Benefited: Yes
Time Spent: 60 minutes
Psychotherapy Start time: 08:00
Psychotherapy Stop time: 09:00
Current Session Review: Follow-up #1

Pain
DVPRS Pain Scale: 0 - No pain

Medication Side Effects
SM reported no adverse medication side effects.

Pertinent Collateral Information
Command Contact: CPT Nathan Anderson (02/10/23 10:23:00)
Pertinent Collateral Information: 786-201-7037 (02/10/23 10:23:00)
Referral Source: Self (02/10/23 10:23:00)
Unit and Phone Number: HSC, HHBN7125794162 (02/10/23 10:23:00)

Objective

MSE
Mood: Dysphoric, Sad, Other: Neutral
Thought Process: Intact
Appearance.: Appropriately dressed and groomed
Speech: Normal
Affect: Full
Thought Content.: Non-psychotic
Insight.: Fair
Judgment: Fair

Past Psychiatric History
Prior Behavioral Health Care: No
Prior Behavioral Health Care Comments: SM DENIED.
Prior Medication Treatment: No
Prior Medication Treatment: SM DENIED.
Prior Suicide Attempts: No
Prior Suicide Attempts: SM DENIED.
History of Other Self Harm Behaviors: No
History of Other Self Harm Behaviors: SM DENIED.
Harm to Others/Violent Behavior: No
Prior Harm to Others/Violent Behavior: SM DENIED.
Additional Treatment Comments: No additional treatment comments.

Trauma, Abuse and Patient Safety
Physical Abuse: No
Physical Abuse Comments: SM DENIED.
Emotional Abuse: No
Emotional Abuse Comments: SM DENIED.
Sexual Activity: No
Sexual Abuse Comments: SM DENIED.

Office and Clinic Notes

Experienced Neglect: No
Neglect Comment: SM DENIED.
Experienced Exploitation: No
Experienced Exploitation Comments: SM DENIED.
Does Patient Feel Safe at Home: Yes
Other Traumatic Event: No
Other Trauma Comments: SM DENIED.

Military Trauma
Military Service-Related Trauma: No
Military Service Trauma Comments: SM DENIED.

Risk Assessment

Access to Weapons: Yes
Access to Weapons Detail: Husband has 1 pistol for home defense; it is stored in the top of a closet in a lockbox.
Warning Signs- BH: Agitation, Anger, Anxiety, Feeling trapped, Mood change
Protective Factors- BH: Adequate medical/mental health support, Financial stability, Good impulse control, Help seeking, Intact marriage, Safe and stable environment
General Risk Factors- BH: Access to firearms or other lethal means, Relationship problems/break-up

Suicide Risk Level
Is the Patient at Risk: Yes, risk detected
Acute Suicide Risk CSRE: Low
Chronic Suicide Risk CSRE: Low
Morbid Ideation: Denies
Suicidal Ideation: Denies
Suicide Method: Denies
Suicide Plan Created: Denies
Suicide Intent: Denies
Suicide Attempt: Denies
Suicide Risk Details: NO SUICIDE RISK DETECTED

Homicide Risk Level
Violence Risk Assessed As: Not Detected
Assault Ideation: Denies
Homicide Ideation: None
Recent Homicide or Assault Attempt: Denies
Violence Risk Details: NO VIOLENCE RISK DETECTED

Coping and Safety Plan Safety Plan Reviewed with Patient: Not clinically indicated

Assessment and Treatment Plan

Diagnosis
1. Postpartum depression
Diagnosis: **1**. Postpartum depression
Comment:
Ordered: Psychotherapy 60mins w/ Patient 90837; 02/10/2023 09:12:00 CST
Other status: Emot/Behavl Assess w/Score & Doc; per tool 96127; 02/10/2023 08:00:00 CST, CSSRS-Current;, 1 (Completed)

End of Orders

Overall Assessment/Case Conceptualization: Pt reported experiencing situational anxiety. One situation that triggers anxiety is when she is driving and loses phone signal. She will become fidgety, her heart will race, she will

Office and Clinic Notes

struggle to catch her breath, and she will become pale. This will last for several minutes and then spontaneously resolve. During that time, she will worry about what would happen if she had a medical problem and could not contact anyone or got into an accident. She also may be at home (not necessarily alone) and will experience an anxiety attack for no apparent reason. The anxiety began about 2 years ago and has no identifiable trigger aside from it being the first time that she began driving long distances by herself. Her anxiety may occur daily and has not occurred for as long as one month. The pt never has gone to the ER for an anxiety attack. She reported that her paternal grandmother has anxiety, and she believes that she takes medication for it.

The pt reported that her depressive symptoms began around August 2022. She experienced an "overwhelming sadness" during which she did not want to do anything. The first episode lasted about one week. Subsequent episodes occurred 1-2 times per week and lasted 1-2 days. She felt better during the day when she spent time with her daughter and overcome with sadness after she put her daughter to bed. The patient denied symptoms of hypomania and mania. She described her depression over the last couple of weeks as undulating between depression and feeling normal. Her paternal grandmother also has depression.

The pt denied ever taking any OTC or prescription medication for anxiety or depression.

Prognosis for Tx is assessed to be: Good.

SUICIDALITY MANAGEMENT PLAN (If applicable; must have if Intermediate or high risk): NO SUICIDALITY NECESSITATING MANAGEMENT PLAN.
1. The patient will follow-up in outpatient psychotherapy to address treatment goals noted below.
2. Persons notified: **NO ONE NOTIFIED TODAY.**
3. Patient demonstrated ability to make use of a crisis response plan and has agreed to do so.
4. Patient will **NOT** be added to High Interest Program with Command Interest.

Crisis Response Plan: Present to IACH Emergency Department, call 911, call MPs, First Sergeant or primary supervisor if feeling suicidal.

Follow up: Patient was scheduled for next follow-up appointment **FRI 24 FEB at 09:30; and THU 09 MAR at 09:00.**

Referrals: No referrals to other specialty services are required at this time.

Consultations: No new consultations are indicated at this time.

Disposition: RETURN TO DUTY; PLANS TO RESIGN OFFICER COMMISSION WITHIN ONE YEAR.

Profile Status: No Behavioral Health Profile
Pt remains fit for duty

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Is Soldier cleared through Behavioral Health to carry and fire a weapon?.....	Yes
Is Soldier cleared through Behavioral Health for current security clearance?.....	Yes
Is Soldier cleared through Behavioral Health for deployment or TDY?.....	Yes
Is Soldier able to perform his/her MOS, without restrictions for BH reasons?.....	Yes

This Provider will continue to follow Service Member throughout behavioral health treatment.

KRISTINE SOBERING, CIV, ARMY, LSCSW, LCAC, MAC
IACH MULTI-D BEHAVIORAL HEALTH CLINICAL SOCIAL WORKER

Prognosis
Prognosis: Good

General Treatment Planning
Benefits, Risks, Alternatives Discussed: Yes
Treatment Plan: Encourage balanced diet, Exercise 4-5 times / week, Practice good sleep hygiene, Referral to individual, family or group therapy, Other: Referral to off-post marital therapy per Teri Nelsen.
Number of Visits Expected: 4-8
Target Symptoms: Anxiety, Depression, Relationship issues
Goals of Treatment: Improve overall functioning, Decrease in target symptoms
Methods of Monitoring Outcomes: Other: Reduced BASIS-24 (emotional lability) and K6 (general distress)
Evaluation Type: By complexity
Objectives of Treatment #1: reduce bereavement, sadness symptoms and anxiety symptoms
Goals of Treatment #1: Decrease in target symptoms
Interventions of Treatment #1: CBT; Interpersonal therapy
Objective #1 Goal Status: Initial
Objective #1 Start Date: 02/10/23
Objective #1 Comment: intake
Treatment Planning Requirements: 1) Developed treatment plan collaboratively with patient, with agreement on plan of care and goals, 2) Patient agrees to attend appointments, engage in treatment, discuss any concerns in order to meet treatment goals, 3) Provider will leverage patient strengths and limit potential barriers to treatment

Disposition
Disposition
Psychologically fit for full duty: Yes
Command Consultation: No
Issued Profile/DLC/LIMDU: No
Able to Carry and Fire a Weapon: Yes
BH Able to Deploy: Yes
Change in Special Duty: No
Change in Security Clearance: No
MEB Referral/In Progress: No

Office and Clinic Notes

Admin Separation Referral/In Progress: No
Disposition Comment: RETURN TO DUTY

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Kristine Sobering, CIV, ARMY, LSCSW, LCAC, MAC
Behavioral Health Clinical Social Worker
Multi-Disciplinary Clinic
Irwin Army Community Hospital
Fort Riley, KS

Electronically Signed on: 02/10/2023 11:18 CST

SOBERING, KRISTINE K, LCSW

Document Type: Mental Health Outpt Note
Service Date/Time: 2/3/2023 11:19 CST
Result Status: Auth (Verified)
Perform Information: PREWITT,JENNIFER ANN,PhD (2/6/2023 11:30 CST)
Sign Information: PREWITT,JENNIFER ANN,PhD (2/6/2023 11:30 CST)

Behavioral Health

High Interest
High Interest: No

Special Duty
Arming Status/Weapons Qualification: No (02/03/23 13:33:00)
Aviation (Flight): No (02/03/23 13:33:00)
Dive: No (02/03/23 13:33:00)
Ionizing Radiation Worker: No (02/03/23 13:33:00)
Jump: No (02/03/23 13:33:00)
Landing Craft Air Cushion: No (02/03/23 13:33:00)
Nuclear Field Duty: No (02/03/23 13:33:00)
Personnel Reliability Program: No (02/03/23 13:33:00)
Presidential Support Duty: No (02/03/23 13:33:00)
Special Operations/Warfare: No (02/03/23 13:33:00)
Submarine: No (02/03/23 13:33:00)

BHDP Data

Measure	Baseline/ First Score	Previous Score	Most Recent Score	Most Recent Score Interpretation	Most Recent Date
AUDIT-C Alcohol Use Disorders Screener	1			Based on clinical assessment, brief alcohol counseling in primary care may be considered (e.g., medication interaction, safety concerns).	03Feb2023

Problem List/Past Medical History

Ongoing
- Ankle pain
- Anxiety disorder, unspecified
- Cholelithiasis
- Depression, unspecified
- Diastasis recti
- Hirsutism
- Missed miscarriage
- Pain in right knee
- Pain of knee region
- Pain of right ankle joint
- Pelvic and perineal pain
- Vaginal granulation tissue

Historical
- Bells palsy of left side of face
- Childbirth education done
- Normal pregnancy in primigravida
- Other specified counseling
- Pregnant
- Pregnant

Procedure/Surgical History

- Cholecystectomy Laparoscopy (No Laterality) (09/15/2022)

Office and Clinic Notes

BASIS-24 **Emotional Lability Subscale** General Distress	2.89			High Level of Distress	03Feb2023
BASIS-24 **Psychosis Subscale** General Distress	0			Subclinical to Low Level of Distress	03Feb2023
BASIS-24 **Relationships Subscale** General Distress	0.1			Subclinical to Low Level of Distress	03Feb2023
C-SSRS-S Lifetime Screener Suicide Risk	**Green**			No Follow-up Indicated.	03Feb2023
C-SSRS-S Past Month Suicide Risk	**Green**			No Follow-up Indicated.	03Feb2023
CSI Couples Satisfaction Index	5			Some Likely Relationship Distress Reported. Evaluation Indicated.	03Feb2023
WRAIR + Social Impairment **Personal or Social/Occupational/Leisure (subscales)** Functional Impairment	781/1554/1				03Feb2023
GAD7 Anxiety Screener	7			No Anxiety Syndrome Detected.	03Feb2023
ISI Insomnia Symptoms	3			No Clinically Significant Insomnia.	03Feb2023
K6 General Distress	10			Moderate Distress.	03Feb2023
Pain Physical Pain Rating	2				03Feb2023
PHQ9 Depression Symptoms	6			No Depressive Syndrome Detected.	03Feb2023
TBI Screen Traumatic Brain Injury	**Negative**			Negative on TBI Screen.	03Feb2023

Informed Consent
Reviewed limits of confidentiality prior to initial encounter; patient expressed understanding and agreed to proceed
Informed Consent Discussed and Given: Yes

	Yes	No
Patient confirmed s/he attended this session voluntarily?	x	
Visit is deployment-related?		x
Visit is accident-related?		x
Has the patient had an unexplained fall in the last 3 months?		x
If Yes, was that fall due to tripping over an obstacle?		
Does the patient feel abused, neglected or exploited at home?		x
If Yes, by whom and how often?		

Chief Complaint
"2nd Trimester miscarriage, depression, and anxiety"

History of Present Illness/Subjective
Pt reported that she experiences situational anxiety. One situation that triggers anxiety is when she is driving and loses phone signal. She will become fidgety, her heart will race, she will struggle to catch her breath, and she will become pale. This will last for several

Medications
penicillin V potassium 500 mg oral tablet, 500 mg= 1 tab(s), Oral, BID
Prenatal Multivitamins with Folic Acid 1 mg oral tablet, 1 tab(s), Oral, Daily, 3 refills
Refresh Plus ophthalmic solution, 1 drop(s), Eye-Both, every 2 hr, PRN, 6 refills

Allergies
No Known Allergies

Social History
Alcohol
Never Use:., 02/03/2023
E-Cigarette/Vaping
Never - E-Cigarette/Vaping user Electronic Cigarette Use:., 09/02/2022
Employment/School
Work/School description: Active duty. Highest education level: University degree(s)., 05/06/2021
Exercise
Physical Activity Consultation: Counseled to maintain physical activity., 05/06/2021
Home/Environment
Lives with Spouse. Marital Status of Patient if Patient Independent Adult: Married. Spouse Name: Joshua Journet. Living situation: Home/Independent. Feels unsafe at home: No., 05/06/2021
Nutrition/Health
Diet: Regular., 05/06/2021
Sexual Orientation and Gender Identification (SOGI)
Sexually active: Yes. Sexual orientation: Straight or heterosexual. What is your current gender identity? (Check all that apply) Identifies as female. History of sexual abuse: No., 05/06/2021
Substance Use
Never Use:., 11/30/2022
Tobacco
Exposure to Secondhand Smoke: No. Never-cigarette user Cigarette use:. Never-other tobacco user (not cigarettes) Other Tobacco use:., 12/20/2022
Never-cigarette user Cigarette use:. Never-other tobacco user (not cigarettes) Other Tobacco use:., 12/12/2022

Family History
Breast cancer: Paternal Grandmother - FH.
Cancer: Paternal Grandmother - FH.
Heart attack: Maternal Grandmother - FH.
Hypertension: Paternal Grandmother - FH.

Office and Clinic Notes

minutes and then spontaneously resolve. During that time, she will worry about what would happen if she had a medical problem and could not contact anyone or got into an accident. She also may be at home (not necessarily alone) and will experience an anxiety attack for no apparent reason. The anxiety began about 2 years ago and has no identifiable trigger aside from it being the first time that she began driving long distances by herself. Her anxiety may occur daily and has not occurred for as long as one month. The pt never has gone to the ER for an anxiety attack. She reported that her paternal grandmother has anxiety, and she believes that she takes medication for it.

The pt reported that her depressive symptoms began around August 2022. She experienced an "overwhelming sadness" during which she did not want to do anything. The first episode lasted about one week. Subsequent episodes occurred 1-2 times per week and lasted 1-2 days. She felt better during the day when she spent time with her daughter and overcome with sadness after she put her daughter to bed. The patient denied symptoms of hypomania and mania. She described her depression over the last couple of weeks as undulating between depression and feeling normal. Her paternal grandmother also has depression.

The pt denied ever taking any OTC or prescription medication for anxiety or depression.

Pain
DVPRS Pain Scale: 2 - Notice pain, does not interfere with activities
Primary Pain Location: Knee
Pain Follow Up: Pain is being addressed

Medication Side Effects
N/A; pt does not take psychotropic medication

Pertinent Collateral Information
Command Contact: CPT Nathan Anderson (02/03/23 13:33:00)
Pertinent Collateral Information: 786-201-7037 (02/03/23 13:33:00)
Referral Source: Self (02/03/23 13:33:00)
Unit and Phone Number: HSC, HHBN7125794162 (02/03/23 13:33:00)

Objective

MSE
Level of Consciousness: Alert
Affect Range: Appropriate
Affect Congruence: Congruent with mood, Congruent with thought content
Behavior: Cooperative, Pleasant
Mood: Sad, Other: Neutral
Memory: Short term memory intact, Long term memory intact
Concentration: Able to focus
Hallucinations Present: None
Delusions: None
Thought Process: Intact
Psychomotor Behavior: No problem identified
Speech Rate BH: No problem identified
Speech Rhythm: No problem identified
Speech Volume: No problem identified
Speech Amount: No problem identified
Speech Articulation: No problem identified
Orientation: Oriented x 4
Interaction BH: Initiates interaction with staff
Appearance.: Appropriately dressed and groomed

Musculoskeletal: Observed muscle strength/tone within normal limits
Gait/Station: Within normal limits
Speech: Normal
Affect: Full
Thought Content.: Non-psychotic
Insight.: Good
Judgment: Good
Language: Within normal limits
Fund of Knowledge: Adequate

Past Psychiatric History
Prior Behavioral Health Care: No
Prior Medication Treatment: No
Prior Suicide Attempts: No
History of Other Self Harm Behaviors: No
Harm to Others/Violent Behavior: No
Additional Treatment Comments:

Psychosocial History

Detailed Substance History
Alcohol History of Use: Current use within last 3 months
Alcohol Specific/Type of Sub: Wine
Alcohol Volume/Quantity: 1 drink
Alcohol Frequency grid: Monthly
Alcohol Method of Use: Oral
Opioids History of Use: No history of use
Cannabinoids History of Use: No history of use
Cocaine/Crack History of Use: No history of use
Hallucinogens History of Use: No history of use
Inhalants History of Use: No history of use
Sedatives and/or Tranqlzr History of Use: No history of use
Stimulants, Other History of Use: No history of use
Alcohol Age of First Use: 21
Other drugs History of Use: No history of use
Tobacco (Nicotine) History of use: No history of use
Addictive Behaviors: No reported concerns
Problems due to substance use: Denies

Trauma, Abuse, and Patient Safety
Physical Abuse: No
Emotional Abuse: No
Sexual Activity: No
Experienced Neglect: No
Experienced Exploitation: No
Does Patient Feel Safe at Home: Yes
Other Traumatic Event: No

Military Trauma
Military Service-Related Trauma: No

Family Involvement
How was your childhood: Great
Place of Birth: Miami, Florida
Raised By: Father, Mother
Current Relationship/Marital Status: Married-Civil
Family Involvement Additional Information: DOM: 10/08/2018 SM reported that her

Office and Clinic Notes

parents are currently divorced, at the age of 2. SM indicated that she has a "good relationship" with both of her parents and endorsed them as having a good coparenting relationship. She primarily lived with her mother and spent every other weekend with her father. She also saw her father on Tuesdays and Thursdays. SM stated that she has 1 biological brother (26) and 1 half-sister (18). Her half-sister lived with their father. SM noted that she has a good relationship with both siblings. The pt described school as "pretty good" and reported earning "usually As and Bs, but sometimes Cs" in math. She reported that she always was in advanced classes and was in dual enrollment in 11th and 12th grades. Following graduation, she attended Florida International University where she studied Criminal Justice and earned her bachelor's degree. Although she was not in ROTC, she decided that she wanted to join the military when she began studying criminal justice. She took a few months off after graduating college and then joined the Army. The pt reported that she met and began dating her husband in high school, when she was 16. He is two years older than she. She met him through her first job. They married when the patient was 20. Her husband medically retired from the Army and currently is a stay-at-home dad. He also is trying to start a snake breeding business. SM noted that she would like to "better" her relationship with husband. They have one daughter, age 14 months. They suffered a miscarriage in late December 2022 when the pt was 17 weeks pregnant.

Risk Assessment
Access to Weapons: Yes
Access to Weapons Detail: Husband has 1 pistol for home defense; it is stored in the top of a closet in a lockbox.
Warning Signs- BH: Agitation, Anger, Anxiety, Feeling trapped, Mood change
Protective Factors- BH: Adequate medical/mental health support, Financial stability, Good impulse control, Help seeking, Intact marriage, Safe and stable environment
General Risk Factors- BH: Access to firearms or other lethal means, Relationship problems/break-up

Suicide Risk Level
Is the Patient at Risk: No, risk not detected
Acute Suicide Risk CSRE: Low
Chronic Suicide Risk CSRE: Low
Morbid Ideation: Denies
Suicidal Ideation: Denies
Suicide Method: Denies
Suicide Plan Created: Denies
Suicide Intent: Denies
Suicide Attempt: Denies
Suicide Risk Details:

Homicide Risk Level
Violence Risk Assessed As: Not Detected
Assault Ideation: Denies
Homicide Ideation: None
Recent Homicide or Assault Attempt: Denies
Violence Risk Details:

Coping and Safety Plan
Crisis Response Plan: Present to IACH Emergency Department, call 911, call MPs, First Sergeant or primary supervisor if feeling suicidal.
Safety Plan Reviewed with Patient: Not clinically indicated

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Assessment and Treatment Plan

Formulation
The pt presents with anxiety with strong physiological manifestation and with depression that appears to be cyclical. At times, the depression is situational and related to still being at work when she was supposed to have been out of the Army already. At other times, the depression appears to be organic. The pt reported that her paternal grandmother is diagnosed with depression and anxiety and that she takes medication for them.

Diagnosis
1. Anxiety disorder, unspecified
2. Depression, unspecified

Prognosis
Prognosis: Good

General Treatment Planning
Benefits, Risks, Alternatives Discussed: Yes
Treatment Plan: Encourage balanced diet, Exercise 4-5 times / week, Practice good sleep hygiene, Referral to individual, family or group therapy, Other: Referral to off-post marital therapy per Teri Nelsen.
Number of Visits Expected: 4-8
Target Symptoms: Anxiety, Depression, Relationship issues
Goals of Treatment: Improve overall functioning, Decrease in target symptoms
Methods of Monitoring Outcomes: Other: Reduced BASIS-24 (emotional lability) and K6 (general distress)
Evaluation Type: Psychiatric diagnostic evaluation
Objectives of Treatment #1: Develop Treatment Goals with provider
Treatment Planning Requirements: 1) Developed treatment plan collaboratively with patient, with agreement on plan of care and goals, 2) Patient agrees to attend appointments, engage in treatment, discuss any concerns in order to meet treatment goals, 3) Provider will leverage patient strengths and limit potential barriers to treatment

Disposition
Disposition
Psychologically fit for full duty: No
Command Consultation: No
Issued Profile/DLC/LIMDU: No
Able to Carry and Fire a Weapon: No
BH Able to Deploy: No
Change in Special Duty: No
Change in Security Clearance: No
MEB Referral/In Progress: No
Admin Separation Referral/In Progress: No
Disposition: RTD

Jennifer Prewitt, Psy.D.
Clinical Psychologist
Multi-Disciplinary Clinic
Irwin Army Community Hospital
Ft. Riley, Kansas

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Office and Clinic Notes

entries that include "No qualifying data available" reference information that may be recorded in this encounter's associated form.

Electronically Signed on: 02/06/2023 11:30 CST

_____

PREWITT, JENNIFER ANN, PhD