Psychiatric History Form

Demographic Information

First name Last name is a 21-year-old, divorced, Caucasian, other, East Indian, female. Who goes by a preferred pronoun of she/her/hers. person@people.com 111-111-1111

Employment Information

Current Employer (If Different Than Above)

Employment Where the Physical or Emotional Injury Occurred

Name of your current employer:

IBM

What is the nature of this business:

IBM is a company that specializes in computers.

Date this job began:

The patient started working at IBM on January 1, 2004.

What was the last day you worked at this job?

The patient's last day of work at IBM was on January 1, 2023.

Your job title when you started this employment:

The patient's job title when they started working at IBM was a programmer.

Your current title or title when you ended this employment:

The patient's current title or title when they ended their employment at IBM was a manager.

Your employment duties:

The patient's employment duties at IBM included turning computers on and off.

Your typical work schedule (hours worked per day, week, or month):

The patient worked 40 hours per week at IBM.

Your salary:

The patient's salary at IBM was $1,000,000.

Hourly Rate:

The patient's hourly rate at IBM was $1,000.

Do you receive overtime pay?

Yes, the patient receives overtime pay.

How much overtime pay do you typically receive?

The patient typically receives $100 in overtime pay.

What do you like about this job?

The patient likes this job because it pays well.

What do you not like about this job?

The patient does not like this job because they do not like computers.

BEFORE the injury, were you being treated for any physical or medical condition(s)?

Yes, the patient was being treated for a physical condition before the injury.

BEFORE the injury, were you being treated for any mental or emotional condition(s)?

Yes, the patient was being treated for a mental or emotional condition before the injury.

BEFORE the injury, were you experiencing any emotional symptoms?

Yes, the patient was experiencing emotional symptoms before the injury.

Describe these medical or emotional conditions or symptoms BEFORE the injury:

Before the injury, the patient had difficulty walking and was experiencing depression.

Were you taking any medications BEFORE the injury?

Yes, the patient was taking medications before the injury.

What medications were you taking BEFORE the injury?

The patient was taking Morphine before the injury.

Date of your injury (if more than one, list each):

The patient had multiple injuries on January 1, 2004, February 1, 2014, and March 1, 2022.

Describe the injury that occurred (provide as many details as you can):

The patient described the injury as hating their boss and their boss being mean to them.

Do you currently receive disability in connection with your claim?

Yes, the patient currently receives partial temporary disability.

Would you have continued working if not injured?

Yes, the patient would have continued working if not injured.

Are you currently working?

Yes, the patient is currently working.

Have you had any conflicts with anyone at Work?

Yes, the patient has had conflicts with others at work.

How many separate conflicts have you had with others at work?

The patient has had four separate conflicts with others at work.

Please list separately and explain each conflict that occurred:

1. The patient's boss was mean.
2. The patient's coworker stole their stuff.
3. The patient found the customers difficult to deal with.
4. The patient's boss refused to turn on the AC, making it too hot.

Please rate the percentage that each of these conflicts caused you to feel upset, out of a total of 100%:

1. Conflict #1: 20%
2. Conflict #2: 30%
3. Conflict #3: 10%
4. Conflict #4: 40%

What was/is your working relationship like with management or supervisors in general?

The patient's working relationship with management or supervisors in general was terrible.

Name of your immediate supervisor:

The patient's immediate supervisor's name is "bad boss".

Relationship with immediate supervisor?

The patient's relationship with their immediate supervisor is poor.

Explain the reason:

The patient's relationship with their immediate supervisor is poor because they are mean.

How were your performance appraisals?

The patient's performance appraisals were poor.

Explain reason:

The patient's performance appraisals were poor because they were told they couldn't do their job well.

Have you ever received verbal or written warnings?

Yes, the patient has received verbal warnings.

Describe dates and reason given:

On January 1, 2022, the patient received a verbal warning stating that they were not performing well in their job.

Working relationship with co-workers?

The patient's working relationship with co-workers is poor.

Please give the names and reasons this relationship was poor.

The patient's working relationship with co-workers is poor because they believe their co-workers are stupid.

Was there a 'last straw' event near the last day of work?

Yes, there was a 'last straw' event near the patient's last day of work.

Please describe your 'last straw' event near the last day of your work:

The patient's 'last straw' event near their last day of work was that it was too hot and their boss refused to turn on the AC.

Psychiatric Patient Report

Generalized Anxiety Disorder (GAD-7)

Current Employment Information

- Do you currently work for the same employer where the above injury occurred? No
- Name of current employer: Give me a house
- Nature of business: housing
- Job title: squatter
- Job duties: find houses
- Date this job began: 8/1/23
- Your schedule, hours worked per (day, week, month): weekends 9-5
- Salary or hourly rate: $5/hr
- Do you like this job? No

Physical Injury

Initial Symptoms

- If your injury was initially physical, describe the first symptoms (pain) you experienced: knees hurt

Initial Treatment

- If your injury was initially physical, describe the first treatment you received following this injury (medical, chiropractic, physical therapy pt, injections): injections

Subsequent Treatment

- If your injury was initially physical, describe the rest of your treatment (medical, chiropractic, pt): medications

Doctors Seen

- List the doctors you have seen for this physical injury: Dr. Smith, Dr. Jones

Surgery

- Did you receive surgery for this injury? Yes
- List the surgeries you have received for this physical injury: elbow

Medications

- List the medications you have received for this physical injury: Vicodin

Pain Relief

- Have any of the above treatments helped relieve your pain? Yes

Employment Status

- Are you still working? Yes
- If not working, reason for leaving? N/A I'm working

Emotional Symptoms and Injuries

Current Emotional Stressors

- I am most bothered on this day by the following: my boss

Current Emotional Symptoms

- What emotional symptoms are you currently experiencing or recently experienced? anxiety, panic, depression, post-traumatic stress, mania, hypomania, psychosis, other
- When did this current episode of these emotional symptoms begin? several months ago

Triggering Event

- Have you experienced any of your above emotional symptoms in response to a specific stressful event in your life? Yes
- What was the stressful event that triggered your emotional symptoms? My boss was mean to me.

Stressors

- Do you have stress from any of the following? loss of a job or other financial changes, unstable housing, death or loss of a friend or relative, relationship stress such as friends, significant others, or family members, housing, career changes, new children and other family changes

Longitudinal History

Onset of Emotional Symptoms

- When did this episode of your depression, anxiety, or post-trauma emotions start? 7/1/23

Emotional/Psychiatric Symptoms

- Describe the emotional/psychiatric symptoms you have experienced: depressed, anxiety, stress, anger

Severity of Symptoms

- During this current or most recent symptom episode, when were your symptoms the worst?

yesterday

- Have your emotional symptoms become worse or better since they started or since a specific date or event? worse
- On what date did your emotional symptoms become worse or better? 7/4/23
- How often do you feel the above emotions? all day every day
- How would you rate your depressive, anxiety, or post-trauma symptoms when they were most severe, with zero to 1 equaling no or minimal symptoms and 10 equaling the most severe symptoms imaginable?
    - Depressive: 10
    - Anxiety: 9
    - Post-Trauma: 8
- Currently, how do you rate your depressive, anxiety, or post-trauma symptoms on the same 1-10 scale? 6

Impact on Work

- Have Your Emotional Symptoms Affected Your Ability to Do Your Job? Yes
- Please describe how your emotional symptoms have affected your ability to do your job: low energy, get sad, can't focus

Current Symptoms

PHQ-9

Loss of Interest or Pleasure

- Little interest or pleasure in doing things? several days
- If you have lost the ability to enjoy activities that were previously enjoyable, please list those activities that you used to but no longer enjoy: biking

Feeling Down or Hopeless

- Feeling down, depressed, or hopeless? more than half the days
- Have your depressive symptoms improved, become worse, or stayed the same since they started? gotten worse
- How often do you feel depressed during this or your most recent episode? several days per week
- When you experience depression, does it last a majority of the day for most days of the week? Yes

Sleep Disturbances

- Over the last 2 weeks, have you had trouble falling or staying asleep, or sleeping too much? several days
- How many times do you wake up per night before the time you plan to wake up? two
- If trouble staying asleep, when you wake up during the night, how long do you stay awake for? 1-2 hours
- Do any of the following awaken you from sleep? physical pain
- What is the total number of hours you sleep per 24 hours? 4-6 hours

Fatigue

- Over the last 2 weeks, have you been feeling tired or having little energy? several days

Appetite Changes

- Over the last 2 weeks, have you had poor appetite or been overeating? more than half the days
- If you have gained or lost weight recently, how many pounds have you gained or lost? gained 36-50+
- How long did it take you to gain or lose this weight? 1-3 months

Negative Self-Perception

- Over the last 2 weeks, have you been feeling bad about yourself · or that you are a failure or have let yourself or your family down? nearly every day

Concentration Difficulties

- Over the last 2 weeks, have you had trouble concentrating on things, such as reading the newspaper or watching television? several days

Psychomotor Changes

- Over the last 2 weeks, have you been moving or speaking so slowly that other people could have noticed? Or so fidgety or restless that you have been moving a lot more than usual? more than half the days

Suicidal Thoughts

- Over the last 2 weeks, have you had thoughts that you would be better off dead, or thoughts of hurting yourself in some way? nearly every day
- In the past month, have you wished you were dead or wished you could go to sleep and not wake up? more than half the days
- In the past month, have you had any actual thoughts of killing yourself? Yes
- Have you been thinking about how you might kill yourself? Yes
- Have you had these thoughts, and had some intention of acting on them? Yes
- Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan? Yes
- Have you ever done anything, started to do anything, or prepared to do anything to end your life? Yes

Homicidal Thoughts

- Do you have thoughts of hurting anyone else? Yes

Current Depressive Symptoms

- With zero to 1 equaling no or minimal symptoms and 10 equaling the most severe symptoms possible, how do you rate your current depressive symptoms? 4

Current Treatment

Anxiety Symptoms

The patient reports feeling nervous, anxious, or on edge several days over the last 2 weeks. They have been feeling

anxious for several months and experience anxiety several days per week. The patient worries about physical pain, employment situation, financial situation, relationships, family difficulties, family death, previous trauma, conflicts with family or at employment, medical condition, and other things. Going to work specifically makes their anxiety worse. They also have trouble relaxing, feel restless and irritable several days over the last 2 weeks. They feel afraid as if something awful might happen more than half the days. The patient rates their current anxiety symptoms as a 2 on a scale of 0 to 10.

Panic Attacks

The patient experiences panic attacks, with physical symptoms including increased heart rate, shortness of breath, difficulty swallowing, excessive sweating, lightheadedness, feeling like going to pass out, shaking, feeling of choking, nausea, chest pain, chills or heat, numbness or tingling, feeling detached, fear of "going crazy," and fear of dying. The panic attacks occur once a week and last between 31 to 60 minutes. Being around their boss triggers their panic attacks. The patient states that their panic attacks are unrelated to specific events.

Traumatic Experiences

The patient has experienced past traumatic events, including childhood trauma, intimate partner violence, victim of other violence, sexual assault, witnessing violence, first responder trauma, traumatic loss of loved ones, military combat, and other events. They describe one of their traumatic experiences as their boss being mean to them.

PCL-5 Assessment

The patient reports experiencing repeated, disturbing, and unwanted memories of the stressful experience to a little bit. They have moderately disturbing dreams of the stressful experience several times per week. They feel moderately upset when something reminds them of the stressful experience and have a little bit of strong physical reactions such as heart pounding, trouble breathing, and sweating. The patient avoids memories, thoughts, or feelings related to the stressful experience extremely. They also avoid external reminders of the stressful experience extremely, specifically being around their boss. The patient has a little bit of trouble remembering important parts of the stressful experience. They have moderately strong negative beliefs about themselves, other people, or the world. The patient blames themselves or someone else for the stressful experience or what happened after it quite a bit. They have extremely strong negative feelings such as fear, horror, anger, guilt, or shame. The patient also experiences a moderate loss of interest in activities they used to enjoy. They feel extremely distant or cut off from other people and have extreme difficulty experiencing positive feelings. The patient exhibits quite a bit of irritable behavior, angry outbursts, or acting aggressively. They also engage in extremely risky behavior that could cause harm. The patient feels quite a bit of being "superalert" or watchful or on guard. They feel extremely jumpy or easily startled. The patient has extreme difficulty concentrating and quite a bit of trouble falling or staying asleep. They rate their current post-trauma related symptoms as a 6 on a scale of 0 to 10.

Substance Use

The patient currently takes morphine every day in large doses for the past 10 years. The reason for taking this medication is listed as depression, anxiety, mania, psychosis, PTSD, OCD, and other. The patient explains that their boss makes them depressed. The effects of the current medication on the patient's condition are as follows: depression symptoms have worsened, anxiety symptoms have improved, mania and psychosis symptoms have had no effect, PTSD symptoms have improved, OCD symptoms have worsened, and other symptoms are just right. The patient does not always take the medication as prescribed by their medical provider. They have experienced side effects such as upset stomach/nausea, diarrhea, constipation, insomnia, fatigue, headache, sexual dysfunction, shaking, stiffness, tremors, weight gain, weight loss, withdrawal, and other side effects, which include not wanting to go to work.

The patient's current psychiatric medication treatment provider is Dr. Jones.

Psychotherapy Treatment

The patient has been in psychotherapy treatment for the past 10 years. Their most recent psychotherapy session was yesterday, and they attend sessions weekly. The patient's current psychotherapy treatment provider is Mr. Therapy.

Past History

The patient has previously experienced symptoms of anxiety and post-traumatic stress. They described their post-traumatic stress symptoms as being worried about their work. The patient has also experienced periods of high energy where they did not need to sleep for several days or a week at a time. During this time, they slept fewer than 4 hours per night for 5-7 nights. Their energy when awake was normal, but they felt excessively tired during the day. Their mood during this time was depressed, and they engaged in high-risk behaviors. They also drank alcohol or used other substances during this time.

The patient has never experienced recurrent, intrusive, and time-consuming thoughts, behaviors, or rituals. They have not felt like people they don't know are talking about them or following them, nor have they heard a voice that no one else hears. They have, however, recently been thinking about how they might harm or kill themselves. Their emotional symptoms, such as sadness, depression, and anxiety, have had a negative effect on their work, school, and relationships. The patient first felt depressed 20 years ago and first experienced high levels of anxiety 10 years ago.

The patient has been diagnosed with anxiety, autism spectrum disorder, bipolar disorder, depression, eating disorder, mood disorder, obsessive-compulsive disorder, personality disorder, mania or hypomania, panic attacks, schizophrenia or other psychotic disorder, post-traumatic stress disorder, and mean person disorder.

The patient has taken Oxy for 10 years in the 80s. These past psychiatric medications had no effect on depression symptoms, worsened anxiety symptoms, improved mania symptoms, had no effect on psychotic symptoms, had no effect on PTSD symptoms, improved OCD symptoms, and made the patient sleepy. The medications were stopped due to no longer working, no longer wanting to take them, concerns about the medication, and medication side effects. The patient does not remember if a psychiatrist, psychiatric nurse practitioner, or primary care clinician prescribed the medication. The past clinician who prescribed the medication was Dr. Pills, and they worked at Pull Pusher Hospital. The patient has also seen Dr. Psychiatry from 2000 to 2010, attending monthly sessions.

The patient has received psychotherapy since 1980, attending sessions monthly for several months. The names of their past psychotherapists and the dates they saw them are not provided. The patient also received psychotherapy treatment from 1990 to 1999, but no further details are given.

The patient has been admitted to psychiatric hospitals for worsening depressive symptoms, suicidal ideation, suicide attempts, worsening anxiety symptoms, worsening post-traumatic symptoms, worsening manic symptoms, worsening psychotic symptoms, and for unknown reasons. They received psychiatric medications during their hospitalizations. The names of the hospitals they were admitted to are Hospital one, Hospital two, and Hospital three. They were hospitalized in 1993 and June 2023, with durations of 20 days and 10 days, respectively.

The patient has experienced suicidal ideation and has made 6 suicide attempts using methods such as hanging, stabbing, and overdosing on their medications. The most recent suicide attempt occurred 6 months ago.

The patient has experienced symptoms of ADHD, in addition to the symptoms previously mentioned.

The patient has received additional psychotherapy or psychiatric medication treatment that was not described above, including Ritalin as a child.

The patient has been evaluated by psychiatrists or psychologists for conduct disorder when they were 12 years old.

The patient has been involved in 12 physical altercations or acts of violence.

Psychiatric Patient Report

Relationship History

Substance Use History

The patient reported a history of substance use. They have used caffeine (coffee, pills, soft drinks, etc), alcohol, tobacco or nicotine products, cocaine, heroin, prescription pain medications, marijuana, methamphetamine or other stimulants, MDMA, PCP, or other club drugs, and LSD or other hallucinogens.

The patient currently does not use caffeine, alcohol, tobacco or nicotine products, methamphetamine or other stimulants, MDMA, PCP, or other club drugs. They previously used cocaine but have not recently. They use heroin daily, prescription pain medications weekly, marijuana socially (1-2 times per month), and LSD or other hallucinogens weekly.

The patient provided information on the amount and age of initiation for each substance. They consume 2 cups of caffeine, a pint of alcohol per day, 1 pack of tobacco or nicotine products per day, an 8 ball of cocaine, and 1/8 of marijuana per day. They started using caffeine at the age of 12, alcohol at 16, and marijuana at 25.

The patient last used caffeine today, alcohol yesterday, heroin a week ago, and marijuana today.

The patient reported a history of tolerance to caffeine, alcohol, tobacco or nicotine products, cocaine, heroin, and methamphetamine or other stimulants. They did not experience tolerance with prescription pain medications, marijuana, MDMA, PCP, or other club drugs, or LSD or other hallucinogens.

The patient experienced withdrawal symptoms from caffeine but not from alcohol.

Alcohol and Substance Use Symptoms

The patient reported experiencing the following symptoms related to alcohol and substance use:

- Alcohol or substance is often taken in larger amounts or over a longer period of time than intended.
- There is a persistent desire or unsuccessful effort to cut down or control alcohol or substance use.
- A great deal of time is spent in activities necessary to obtain alcohol or substances, use these, or recover from its effects.
- Craving, or a strong desire or urge to use alcohol or substances.
- Recurrent alcohol or substance use resulting in a failure to fulfill major role obligations at work, school, or home.
- Continued alcohol or substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol or substances.
- Important social, occupational, or recreational activities are given up or reduced because of alcohol or substance use.
- Recurrent alcohol or substance use in situations where it is physically dangerous.
- Alcohol or substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol or substance.
- Tolerance as defined by either a need for markedly increased amounts of alcohol to achieve intoxication or desired effect, or a markedly diminished effect with continued use of the same amount of alcohol or substances.
- Withdrawal as manifested by the characteristic withdrawal syndrome for alcohol or substances.
- Alcohol or substances (or a closely related substance, such as a benzodiazepine) is taken to relieve or avoid withdrawal symptoms.

Substance Recovery Treatment History

The patient reported enrolling in a substance recovery treatment program and completing it. The treatment program lasted from 1993 to 1994. Following this treatment, the patient remained clean and sober for 1 day. The longest period of remaining completely clean and sober from all alcohol and substance use was 1 month in 2021. During this period, the patient continued to experience psychiatric symptoms such as depression and anxiety.

Medical History

General Physical Health

The patient reported being diagnosed with arthritis, asthma, back problems, chronic pain, diabetes, heart disease, hypertension, gastrointestinal problems, migraines, thyroid problems, and other conditions.

General Physical Health Medications

The patient is currently taking lisinopril 20 mg per day for their general physical health.

The patient reported experiencing side effects from their general medical medications, but did not provide specific details.

Surgeries

The patient has undergone surgeries on their elbow and foot in 2020.

Future Medical Care

The patient's treatment providers have plans for their future medical care, which include physical therapy and chiropractic treatment for 6 months.

Primary Care Providers

The patient's current primary care physician or nurse practitioner is Dr. Don't call me. Their past primary care physician or nurse practitioner was Dr. Past Medical, whom they received care from between 1980 and 1990.

Hospitalizations

The patient has been hospitalized at General Medical Hospital in 1999 for medical reasons.

Allergies and Intolerances

The patient reported having an intolerance to penicillin, which causes a rash.

Family History

The patient reported that some of their family members suffer from depression, anxiety, and bipolar disorder. Additionally, some family members have attempted or committed suicide.

Social History

Intimate Relationship

The patient is currently involved in an intimate relationship and is married. They have been in their current relationship for 10 years. The patient describes their current intimate relationship as stable, supportive, and volatile. However, they also mention that the relationship is about to end. The patient's spouse or partner is a bartender. The spouse or partner suffers from a general medical or psychiatric condition, which is stressful for the patient. The specific condition is not mentioned.

Marital History

The patient has been married three times in the past.

Long Term Intimate Relationships

The patient has had a total of six long term intimate relationships. The duration of each relationship was 5 years, 2 years, and 3 years. The reasons for the end of these relationships include moving away and growing apart.

Domestic Violence

There has been domestic violence in at least one of the patient's previous relationships. No further details are provided.

Children

The patient has five children whose ages are not specified. The patient reports that their children are doing well in school or work. The relationship between the patient and their children is described as good. Some of the children have general or mental health issues, but the specific conditions are not mentioned.

Employment History

Current Employment

The patient is currently employed at less than 20 hours per week. They work as a bondsman at a company called Bail Bonds. The patient's job duties include giving out bonds. However, the patient is experiencing difficulty performing their job duties.

Past Employment

The patient's past employer immediately prior to their current job is not provided.

Workplace Injuries

The patient has had past workplace injuries. The injury occurred in 2005 and was a sprained ankle.

Workers' Compensation

The patient has submitted a Workers' Compensation claim in the past.

Disability

The patient has been placed on disability in 2015.

Work Evaluations and Disciplinary Action

The patient has received negative work evaluations in the past and has been told that they are bad at their job. This occurred in 2005. No further details are provided.

Sources of Income

The patient's current sources of income include their employment, other employment, workers' compensation benefits, their spouse's income, and their children's income.

Education History

Highest Level of Education

The patient's highest level of education is a GED.

Grades and Learning Disability

During their education, the patient mostly received grades of Bs and Cs. They were identified as having a learning disability and were placed in special education classes. The patient mentions that they have difficulty reading.

High School and College

The patient graduated from high school but not on time. They also attended college at Smith College but did not complete their degree. The patient's major or primary topic of study at Smith College was writing.

Psychiatric Patient Report

Patient Information

- Name: [Patient's Name]
- Age: [Patient's Age]
- Gender: [Patient's Gender]
- Date of Birth: [Patient's Date of Birth]
- Date of Evaluation: [Date of Evaluation]
- Referring Physician: [Referring Physician's Name]
- Reason for Evaluation: [Reason for Evaluation]

Barriers to Healthcare

The patient reported experiencing barriers to receiving healthcare. These barriers include financial constraint, unstable housing, transportation access, child-care, family disapproval, and other unspecified barriers.

Living Situation

The patient's current living situation includes owning their own home, living with family, living with friends, living alone, and temporary housing.

Perceived Danger

The patient reported feeling in danger at the present time. They described the situation in which they feel in danger as their boss potentially attacking them.

Stressors in the Past Year

The patient reported experiencing stressors in the past year, including their family leaving. These stressors have affected their emotional symptoms, making them feel sad.

Other Stressors Since Injury

The patient reported experiencing additional stressors in their life since their injury. These stressors include financial difficulties, which have also affected their emotional symptoms, causing them to feel stressed about money.

Other Current Stressors

The patient reported experiencing other stressors in their life not covered above, specifically wanting a better car.

Criminal History

The patient reported having been arrested in 1995 on drug-related charges. They were incarcerated in prison for 10 years and are currently on parole or probation.

Violence History

The patient reported having been involved in 20 physical altercations, with the circumstances surrounding these altercations being people disrespecting them. They also expressed thoughts of wanting to hurt their boss by stabbing them.

Victim of Violence

The patient reported having been a victim of violence and currently being in danger of violence.

Military History

The patient reported having enrolled in the Coast Guard from 1999-01-01 to 1999-12-01 as a cook. They received a dishonorable discharge.

Current Daily Activities

The patient provided the following information about their daily activities:

- Wake up on work days: 5 am
- Wake up on non-work days: 6 am
- Bedtime: 10 pm
- Time of falling asleep: 11 pm

Activities from waking up until bedtime:

- 6 am to 8 am: Sleep
- 8 am to 10 am: Eat breakfast
- 10 am to 12 pm: Nothing
- 12 pm to 2 pm: Walk
- 2 pm to 4 pm: Nothing
- 4 pm to 6 pm: Nap
- 6 pm to 8 pm: Nothing
- 8 pm to 10 pm: Work
- 10 pm to 12 am: Go to bed

- 12 am to 6 am: Sleep

Leisure activities or hobbies include smoking.

Daily Living Abilities

The patient provided the following information about their daily living abilities:

- Bathing: Able to do independently
- Dressing: Need help
- Grooming: Need help
- Oral Care: Can't do
- Toileting: Don't do
- Transferring: N/A
- Walking: Can't do
- Cooking: Don't do
- Doing Dishes: Able to do independently
- Eating: Able to do independently
- Shopping: Need help
- Managing Medications: Don't do
- Using the Phone: Can't do
- Housework: N/A
- Doing Laundry: Able to do independently
- Driving: Need help
- Managing Finances: Able to do independently
- Recreation: Don't do

Difficulty Rating

The patient rated their difficulty with the following:

- Concentrating: No difficulty
- Listening: Some difficulty
- Reading: Much difficulty
- Studying: Much difficulty
- Writing: Unable to do

Limitations in Activities

The patient reported that they are unable to smoke due to their condition.

Developmental History

The patient was born in Memphis, TN, and primarily raised in Sacramento. They were primarily raised by their biological mother and father, with a fair relationship. The patient rated their relationship with the primary adults who raised them as medium, indicating some disruption in the relationship and some level of conflicts. They have seven siblings, three of whom they were raised with. Their relationship with their siblings is also rated as medium. The patient experienced physical abuse during their childhood. Their parents were married and remained married. Their mother worked as a doctor and is currently living in Memphis, TN. Their father worked as a janitor and is currently living.

Social Life as a Child

The patient preferred to spend time alone and had few friends during their childhood.

Childhood Activities

The patient enjoyed playing baseball during their childhood.

Additional Information

The patient expressed a desire for disability money and provided positive feedback about the intake form.