Patient: **KLAY, ARIANA BEVIN**
Treatment Facility: **779TH MEDICAL GROUP**
Patient Status: **Outpatient**

Date: **25 Jan 2011 0906 EST**
Clinic: **SOCIAL WORK MG**

Appt Type: **T-CON***
Provider: **PIACQUADIO,MICHELLE A**

Call Back Phone: **(703)-389-4046**

Reason for Telephone Consult: contacted pt to reschedule appt.

AutoCites Refreshed by PIACQUADIO,MICHELLE A @ 25 Jan 2011 0906 EST

Problems
Chronic:
- Bulimia nervosa
- Alcohol dependence in remission
- Anxiety disorder NOS
- Major depression, single episode
- Inquiry and counseling
- Patient education
- Patient education about a proper diet
- Insomnia
- Alcoholism
- Visit for: administrative purposes
- Compression arthralgia of the knee / patella / tibia / fibula

Family History
- Family medical history (General FHx)
- Of mental illness (not retardation) (General FHx)
- Of substance abuse (General FHx)

Allergies
- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
FLUOXETINE HCL, 20 MG, CAPSULE, ORAL	Active	T3 CAP PO DAILY #90 RF1	1 of 1	04 Jan 2011
Ethinyl Estradiol 0.02mg + Drospirenone 3mg, Tablet, Oral, 28 Day Dose Pack	Refill	TAKE 1 TAB PO QD CONSECUTIVE X 63 DAYS #6 RF3	1 of 2	05 Nov 2010

LMP: 15 Jun 2010. Date Basis: unknown.

SO Note Written by PIACQUADIO,MICHELLE A @ 25 Jan 2011 0908 EST
Subjective
Appt. was initially cancelled due to main water break impacting the hospital. Since it was repaired, clinician will see pt today at 1300 as scheduled.

A/P Last Updated by PIACQUADIO,MICHELLE A @ 25 Jan 2011 0908 EST
1. Anxiety disorder NOS

Disposition Last Updated by PIACQUADIO,MICHELLE A @ 25 Jan 2011 0908 EST

Signed By PIACQUADIO, MICHELLE A (Physician/Workstation) @ 25 Jan 2011 0909

Version LDB: 04 Jun 09

DATE: 21 Jan 2011; **DURATION**: 60 min; **Service Provided:** Individual therapy/90806;
SUBJECTIVE: Pt is a 29-yr-old, married, Caucasian female. She is a Marine, 1LT, stationed at Henderson Hall. Pt was referred for individual therapy by Major Morganstein from MGMC Addiction Services. Pt reports symptoms of anxiety connected to unresolved feelings/thoughts related to previous sexual harassment/assault. Treatment is individual therapy with emphasis on Prolonged Exposure Therapy and a primary treatment goal of: decreasing anxiety, building self esteem, decreasing PTSD-like symptoms associated with the unresolved trauma and resolving any underlying contributing factors related to her symptoms.
PROGRESS:
Pt believes that the Prozac is helping her to "be slightly less emotional". Pt continues to face issues related to sexual harassment/sexual assault and is talking to NCIS about the details of the assault and who assaulted her. She plans to tell her husband about the assault, but is highly anxious about hurting him.
-New information for pt's medical provider(s): Pt will continue to see Dr. Thode for psychotropic medication management.
******Due to patient privacy concerns, more complete documentation is kept in separate Mental Health record.** *****

SESSION SUMMARY: *Pt reported that all of her dignity was taken through the sexual harassment and assault. She reports that she is slowly gaining it back although continues to feel degraded when she is asked tough questions by JAG/NCIS. She goes to certain websites at night when she can't sleep that she believes will be validating, such as rape websites, but then feels too overwhelmed to get to sleep. Advised pt to not do this before sleep. She reports difficulty managing the emotional pain related to telling husband about the sexual assault. She denies any bingeing/purging at this time.*
Homework/Results: She completed assignment to address what she is avoiding facing regarding the trauma
PAIN: Not reported or indicated.
Outcome Measures, Monitoring Measures: NA

OBJECTIVE: Mental Status Exam:
Overall: - No unusual or noteworthy change from previously documented MMSE, e.g., appearance, orientation, behavior, interpersonal relatedness, speech patterns, thought content, etc.
MOOD: Slightly less shame-based and burdened as she reports more of the details of sexual assault.
SLEEP: "Not good"; plans to discuss with her psychiatrist;
THOUGHTS: Without Psychoses; tangential at times; some thoughts of guilt/shame about the sexual assault since she was under the influence;
APPETITE: Appetite decreases with stress;
ENERGY: "Ok"
CONCENTRATION: "Ok"
LIBIDO: "Low";
INTERESTS: Accepted to Grad School and is excited about this;
SI: She has thought about whether others would be better off without her because she has caused so much pain (for example, husband), but when questioned, she has no intent or plan;
HI: Denied HI
RISK LEVEL (SI/HI): Minimal/Mild

ASSESSMENT:
Axis I – *Anxiety Disorder NOS – 300.00 per hx*
Alcohol Dependency in early full remission – per hx
Bulimia Nervosa – per hx

R/O PTSD; R/O Depressive Disorder NOS
Axis II – Deferred – 799.9
Axis III – See AHLTA

PLAN: Pt to return to MHC for individual therapy on a weekly basis;
HIGH RISK LOG: No
SAFETY PLAN: Reviewed with pt emergency procedures and phone numbers (MHC 857-7186 during duty hours, ER 857-2333).

DISPOSITION: Pt returned to duty with no limitations
PROFILE/ LIMITATIONS:
-Sensitive Duties: SC
-Profile: No MH
-PCS: Yes
-Deployable: Yes
-Unit notification (if urgent limitations): NA

DETAILS TX PLAN: address how she wants to tell husband about the sexual assault; decrease shame/guilt regarding sexual assault; address bulimic behaviors in therapy and develop tx plan; *begin to identify what she needs/wants to resolve regarding sexual harassment/assault*
Homework: *Pt to address what it is that she avoids facing daily regarding the trauma*
Referrals: None

P: PREVENTION / EDUCATION: Pt encouraged to make healthy lifestyle choices such as: healthy thinking, regular sleep/rest, nutrition, exercise, socializing, family time, couple time, recreations, stress mgt to help prevent exacerbation of symptoms. Pt indicated understanding of above.

EDUCATION MATERIALS: Discussed Prolonged Exposure materials

M.A. Piacquadio, LCSW

Michelle A. Piacquadio, ACSW, LCSW
Licensed Clinical Social Worker, Civ Contractor
Mental Health Clinic, MGMC
Andrews AFB

Version LDB: 04 Jun 09

DATE: 12 Jan 2011; **DURATION**: 60 min; **Service Provided:** Individual therapy/90806;
SUBJECTIVE: Pt is a 29-yr-old, married, Caucasian female. She is a Marine, 1LT, stationed at Henderson Hall. Pt was referred for individual therapy by Major Morganstein from MGMC Addiction Services. Pt reports symptoms of anxiety connected to unresolved feelings/thoughts related to previous sexual harassment/assault. Treatment is individual therapy with emphasis on Prolonged Exposure Therapy and a primary treatment goal of: decreasing anxiety, building self esteem, decreasing PTSD-like symptoms associated with the unresolved trauma and resolving any underlying contributing factors related to her symptoms.
PROGRESS:
Pt's mood continues to improve overall, but she is experiencing ongoing emotional pain related to previous sexual harassment/sexual assault. She finds herself crying often about this. She feels some validation and hope because investigations regarding her former boss have reinforced what pt has reported. Pt continues to remain sober and is working a recovery program. She has agreed to start Prolonged Exposure Therapy with this clinician for symptoms of PTSD related to sexual harassment/assault. Pt has informed her command of the sexual assault and it is being investigated.
-New information for pt's medical provider(s): Pt will continue to see Dr. Thode for psychotropic medication management.
******Due to patient privacy concerns, more complete documentation is kept in separate Mental Health record.** *****

SESSION SUMMARY: *Pt shared details of how she told her commander and other superiors about the rape that occurred by a male friend in her previous command – she didn't reveal his name. Pt has indicated that a new investigation is moving forward related to pt's former boss and pt's sexual harassment/sexual assault allegations. Pt hasn't shared with husband the sexual assault for fear of hurting him. Pt carries a lot of shame about the assault because she had been drinking prior.*
Homework/Results: She completed assignment to address what she is avoiding facing regarding the trauma
PAIN: Not reported or indicated.
Outcome Measures, Monitoring Measures: NA

OBJECTIVE: Mental Status Exam:
Overall: - No unusual or noteworthy change from previously documented MMSE, e.g., appearance, orientation, behavior, interpersonal relatedness, speech patterns, thought content, etc.
MOOD: Tearful when discussing the trauma; reports feeling hopeful overall;
SLEEP: Prazosin is helping to reduce nightmares; she gets to sleep easily, but awakens early;
THOUGHTS: Without Psychoses; tangential at times; preoccupied with guilt/shame about the sexual assault since she was under the influence;
APPETITE: No problems reported; (more information is needed to discern whether pt knows the difference between emotional and physical hunger);
ENERGY: "Good";
CONCENTRATION: "Good";
LIBIDO: "Low";
INTERESTS: Accepted to Grad School and is excited about this;
SI: Denied SI
HI: Denied HI
RISK LEVEL (SI/HI): Minimal

ASSESSMENT:
Axis I – *Anxiety Disorder NOS – 300.00 per hx*

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
MGMC	**AD**	**USAF**	
SPONSOR'S NAME	UNIT	RELATIONSHIP TO SPONSOR	

PATIENTS IDENTIFICATION:	WORK PHONE	HOME PHONE
LAST_NAME, First, Klay, Ariana B **SS#: 20/532-94-8850** **DOB: 07 Jan 1981** **DATE SEEN: 12 Jan 2011**		

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

Alcohol Dependency in early full remission – per hx
Bulimia Nervosa – per hx
R/O PTSD; R/O Depressive Disorder NOS

Axis II – Deferred – 799.9
Axis III – See AHLTA

PLAN: Pt to return to MHC for individual therapy on a weekly basis; recommended pt find a recovery group for bulimia or an OA meeting that has recovering bulimics who attend.
HIGH RISK LOG: No
SAFETY PLAN: Reviewed with pt emergency procedures and phone numbers (MHC 857-7186 during duty hours, ER 857-2333).

DISPOSITION: Pt returned to duty with no limitations
PROFILE/ LIMITATIONS:
- **-Sensitive Duties**: SC
- **-Profile**: No MH
- **-PCS**: Yes
- **-Deployable**: Yes
- **-Unit notification (if urgent limitations)**: NA

DETAILS TX PLAN: decrease shame/guilt regarding sexual assault; address bulimic behaviors in therapy and develop tx plan; *begin to identify what she needs/wants to resolve regarding sexual harassment/assault*
Homework: *Pt to address what it is that she avoids facing daily regarding the trauma*
Referrals: None

P: PREVENTION / EDUCATION: Pt encouraged to make healthy lifestyle choices such as: healthy thinking, regular sleep/rest, nutrition, exercise, socializing, family time, couple time, recreations, stress mgt to help prevent exacerbation of symptoms. Pt indicated understanding of above.

EDUCATION MATERIALS: Discussed Prolonged Exposure materials

M A Piacquadio, LCSW

Michelle A. Piacquadio, ACSW, LCSW
Licensed Clinical Social Worker, Civ Contractor
Mental Health Clinic, MGMC
Andrews AFB

Version LDB: 04 Jun 09

DATE: 4 Jan 2011; **DURATION**: 75 min; **Service Provided:** Individual therapy/90808;
SUBJECTIVE: Pt is a 29-yr-old, married, Caucasian female. She is a Marine, 1LT, stationed at Henderson Hall. Pt was referred for individual therapy by Major Morganstein from MGMC Addiction Services. Pt reports symptoms of anxiety connected to unresolved feelings/thoughts related to previous sexual harassment/assault. Treatment is individual therapy with emphasis on Prolonged Exposure Therapy and a primary treatment goal of: decreasing anxiety, building self esteem, decreasing PTSD-like symptoms associated with the unresolved trauma and resolving any underlying contributing factors related to her symptoms.
PROGRESS:
Overall, mood is better, however, pt continues to experience much emotional pain related to previous sexual harassment/sexual assault. Sleep patterns are continuously disrupted as a result. Pt is working in counseling on ways to improve sleep. Pt denied bingeing and purging since last session.
-New information for pt's medical provider(s): Pt will continue to see Dr. Thode for psychotropic medication management.
******Due to patient privacy concerns, more complete documentation is kept in separate Mental Health record.** *****

SESSION SUMMARY: *Pt reported that she went to Europe for holidays and enjoyed time with spouse and his parents. She has also been accepted into Grad School for Social Work and is thrilled. Pt reported that new information has come to light regarding investigation of her previous boss and it validates what pt has been reporting. Pt has made an IG complaint on her own behalf related to sexual harassment.*
Homework/Results: Pt is reading self-help daily readings
PAIN: Not reported or indicated.
Outcome Measures, Monitoring Measures: NA

OBJECTIVE: Mental Status Exam:
Overall: - No unusual or noteworthy change from previously documented MMSE, e.g., appearance, orientation, behavior, interpersonal relatedness, speech patterns, thought content, etc.
MOOD: Sad, tearful, anxious related to trauma;
SLEEP: Difficulty falling asleep;
THOUGHTS: Without Psychoses; tangential in session;
APPETITE: No problems reported; (more information is needed to discern whether pt knows the difference between emotional and physical hunger);
ENERGY: "Good";
CONCENTRATION: "Distracted";
LIBIDO: "None";
INTERESTS: Accepted to Grad School and is excited about this;
SI: Denied SI
HI: Denied HI
RISK LEVEL (SI/HI): Minimal

ASSESSMENT:
Axis I – *Anxiety Disorder NOS – 300.00 per hx*
Alcohol Dependency in early full remission – per hx
Bulimia Nervosa – per hx
R/O PTSD; R/O Depressive Disorder NOS
Axis II – Deferred – 799.9
Axis III – See AHLTA

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
MGMC	**AD**	**USAF**	
SPONSOR'S NAME	UNIT	RELATIONSHIP TO SPONSOR	

PATIENTS IDENTIFICATION:

WORK PHONE	HOME PHONE

LAST_NAME, First, Klay, Ariana B
SS#: 20/532-94-8850
DOB: 07 Jan 1981
DATE SEEN: 4 Jan 2011

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

PLAN: Pt to return to MHC for individual therapy on a weekly basis; recommended pt find a recovery group for bulimia or an OA meeting that has recovering bulimics who attend.
HIGH RISK LOG: No
SAFETY PLAN: Reviewed with pt emergency procedures and phone numbers (MHC 857-7186 during duty hours, ER 857-2333).

DISPOSITION: Pt returned to duty with no limitations
PROFILE/ LIMITATIONS:
-Sensitive Duties: SC
-Profile: No MH
-PCS: Yes
-Deployable: Yes
-Unit notification (if urgent limitations): NA

DETAILS TX PLAN: address bulimic behaviors in therapy and develop tx plan; *begin to identify what she needs/wants to resolve regarding sexual harassment/assault*
Homework: *Pt to address what it is that she avoids facing daily regarding the trauma*
Referrals: None

P: PREVENTION / EDUCATION: Pt encouraged to make healthy lifestyle choices such as: healthy thinking, regular sleep/rest, nutrition, exercise, socializing, family time, couple time, recreations, stress mgt to help prevent exacerbation of symptoms. Pt indicated understanding of above.

EDUCATION MATERIALS: Suggested daily readings for ED recovery – "Inner Harvest" by Hazelden

M A Piacquadio LCSW

Michelle A. Piacquadio, ACSW, LCSW
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Andrews AFB

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
MGMC	**AD**	**USAF**	
SPONSOR'S NAME	UNIT	RELATIONSHIP TO SPONSOR	

PATIENTS IDENTIFICATION:

WORK PHONE	HOME PHONE

LAST_NAME, First, Klay, Ariana B
SS#: 20/532-94-8850
DOB: 07 Jan 1981
DATE SEEN: 4 Jan 2011

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

Version LDB: 04 Jun 09

DATE: 05 Jan 2011 **DURATION**: 45 min **Service Provided:** Walk-in Assessment/90806
SUBJECTIVE: -Pt is a 29-year-old married, Caucasian, male, AD USN E-5 initially seen in MH Clinic as self-referral. Pt's mother passed away Sep 2010 but found out three weeks ago the cause of death was suicide. Pt was assessed for safety and a treatment direction was developed.

SESSION SUMMARY: Pt learned three weeks ago that the toxicology results indicated the cause of his mother's death in September 2010 was suicide. Pt has been switched from shift work as an Imagery Analyst to day shift in order to attend medical and possible counseling appointments. Pt has experienced trouble sleeping, difficulty concentrating, and low energy for the past three weeks. Pt is "tired of being depressed" and would like to experience better sleep, increased energy, and improved concentration. Clinician educated pt of the stages of grief and emphasized that healing from loss can take time. Clinician and pt agreed that focusing on improving sleep was the most important priority until his intake appointment and discussed ways to improve sleep using proper sleep hygiene techniques.
PAIN: Pt reported headaches (7/10) and neck, shoulder pain (3/10). Pt takes OTC medication for headaches. Encouraged pt to seek tx from PCM.
Outcome Measures, Monitoring Measures: *– OQ.45 results –*

OUTCOME MEASURE or PSYCH TESTING:

OQ45.2 completed, SD= 54 (above 36 indicating possible clinical level concerns); IR= 12 (above 15 indicating possible clinical level concerns), SR= 15 (above 12 indicating possible clinical concern), Tot= 81 (above 63 indicating possible clinical concerns). Critical Items reviewed: #8="Never"; #32="Never"; #44="Never"

OBJECTIVE: Mental Status Exam:
SENSORIUM: Alert and Oriented X4;
BEHAVIOR: Pt was cooperative, pleasant and reasonably attentive, hygiene WNL
APPEARANCE: Appropriately groomed in UOD
MOOD: reported recent/current mood as "depressed".
SLEEP: Decreased. Spend 1.5 hours per night attempting to fall asleep.
APPETITE: Decreased
ENERGY: "No energy"
CONCENTRATION: Difficulty but can function safely
LIBIDO: Decreased
INTERESTS: Decreased
SI: Denied SI
HI: Denied HI
RISK LEVEL (SI/HI): Minimal

ASSESSMENT:
Axis I – V62.82 Bereavement
Axis II – V71.09 No Diagnosis
Axis III – No psychiatric conditions on Axis III
Axis IV – Work
Axis V - 65

PLAN: Patient to return for mental health intake on 10 Jan 2011.
HIGH RISK LOG: No

DISPOSITION: Pt returned to duty with no limitations
PROFILE/ LIMITATIONS:

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
MGMC	**AD**	**USN**	
SPONSOR'S NAME	UNIT	RELATIONSHIP TO SPONSOR	

PATIENTS IDENTIFICATION:

WORK PHONE	HOME PHONE

HORNER, ROBERT
SS#: 20/442-88-7361
DOB: 14 JUN 1981
DATE SEEN: 05 JAN 2011

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

-Sensitive Duties: TS/SCI;
-Profile: No.
-PCS: Yes.
-Deployable: Yes.
-Unit notification (if urgent limitations): NA

DETAILS TX PLAN: Mental Health Intake
Referrals: None

P: PREVENTION / EDUCATION: Pt encouraged to make healthy lifestyle choices such as: healthy thinking, regular sleep/rest, nutrition, exercise, socializing, family time, couple time, recreations, stress mgt to help prevent exacerbation of symptoms. Pt indicated understanding of above.

EDUCATION MATERIALS: Sleep hygiene handout.

Steven M. Hyer, 1LT, USAF, BSC
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Mental Health Flight, MGMC
Andrews AFB

Michelle A. Piacquadio, A.C.S.W., L.C.S.W.
Clinical Social Work Supervisor
Mental Health Flight, MGMC
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HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
MGMC	**AD**	**USN**	
SPONSOR'S NAME	UNIT	RELATIONSHIP TO SPONSOR	

PATIENTS IDENTIFICATION:

WORK PHONE	HOME PHONE

HORNER, ROBERT
SS#: 20/442-88-7361
DOB: 14 JUN 1981
DATE SEEN: 05 JAN 2011

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

Patient: **KLAY, ARIANA BEVIN**
Treatment Facility: **779TH MEDICAL GROUP**
Patient Status: **Outpatient**

Date: **04 Jan 2011 1400 EST**
Clinic: **PSYCHIATRY MG**

Appt Type: **EST**
Provider: **THODE,KIRSTIN T**

Reason for Appointment: f/up
Appointment Comments:
camr

AutoCites Refreshed by THODE,KIRSTIN @ 04 Jan 2011 1403 EST

Allergies
- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
FLUOXETINE HCL, 20 MG, CAPSULE, ORAL	Active	T2 CAP PO DAILY #30 RF0	NR	22 Dec 2010
Ethinyl Estradiol 0.02mg + Drospirenone 3mg, Tablet, Oral, 28 Day Dose Pack	Refill	TAKE 1 TAB PO QD CONSECUTIVE X 63 DAYS #6 RF3	1 of 2	05 Nov 2010

Labs
No Labs Found.
Vitals
No Vitals Found.

LMP: 15 Jun 2010. Date Basis: unknown.

Vitals
Vitals Written by THODE,KIRSTIN @ 04 Jan 2011 1802 EST
BP: 142/80, HR: 73

SO Note Written by THODE,KIRSTIN T @ 06 Jan 2011 0914 EST
Reason for Visit
Visit for: Patient presents to MGMC MH clinic for medication management of anxiety. AHLTA/CHCS & MH chart reviewed. She was last seen by this provider on 1 Dec 10, at which time fluoxetine & hydroxyzine doses increased to better target anxiety & sleep disturbance, respectively. Lt Klay continues to see Ms. Pia for individual therapy.
History of present illness
The Patient is a 29 year old female.
She reported: Past medical history reviewed, problem list reviewed, and medication list reviewed.

This afternoon, patient reports overall feeling better since that appt with this provider. Discussed interval changes to social & occupational/educational functioning. Lt Klay reports that her marriage is going better because she is "not numb all the time." She states that she is enjoying her life with her husband more & describes their holiday trip to Paris & London. Patient also reports taking the GRE for a Master's Degree is Social Work, receiving a high score, & qualifying for scholarship from a local university. She reports having more energy, enthusiasm, & motivation. Lt Klay continues to report nighttime symptoms of ruminations, elevated anxiety, movements in sleep, & nightmares. In the evening, she reports being "easily triggered" to cry & recall traumatic events. Patient denies coping with the continued stress/symptoms by relapsing on EtOH use or binging/purging behaviors. She continues to participate in AA meetings weekly with a sponsor. Husband remains very supportive.
Discussed medication management issues. Lt Klay denies side effects from fluoxetine, reports changing administration time to qAM to assess its effects on her sleep & denies changes to her sleep/nighttime symptoms. She also denies changes to chronic lack of sexual desire. Patient denies effectiveness of hydroxyzine for sleep/nighttime anxiety. She reports taking up to 100mg qHS & having no changes to her symptoms. Discussed sleep hygiene & changes Lt Klay has made to her nighttime behaviors to limit anxiety (i.e. not talking with husband about past trauma & not reading books or watching TV/movies that trigger recollections). Discussed treatment plan. Patient continues to report benefit from therapy with Ms. Pia. She endorses enjoyment of the Caroline Knapp books recommended by this provider as bibliotherapy.
Discussed current legal hold & updates to case. Lt Klay reports a sense of relief & validation in response to recent events. Except as noted above, patient denies current impairing depressive symptoms, to include SI. She denies HI, AVH, manic symptoms, & psychotic symptoms. Lt Klay denies current occupational impairment associated with anxiety symptoms & states that she is doing well when she can stay busy at work.

04 Jan 2011 1400
Facility: NNMC Bethesda, MD Clinic: PSYCHIATRY MG Provider: THODE,KIRSTIN T

Physical findings
Psychiatric Exam:

Performance Of A Mental Status Exam: • A mental status exam was performed - Well-groomed adult, appearing stated age, wearing casual civilian clothes, no apparent distress. Appropriate behavior and cooperative. Psychomotor activity neither increased nor decreased. The patient's speech was fluent and non-pressured. Good eye contact. Mood largely euthymic with congruent affect of mildly restricted range & intensity, non-labile. Patient becomes anxious with behavioral evidence of emotion after seeing an email regarding legal stressors on her cell phone. Fully alert and oriented. Average intelligence based on vocabulary. Thoughts are clear, logical, and goal-directed without loosening of associations or flight of ideas. No auditory or visual hallucinations or delusions. The patient denies any suicidal or homicidal ideation. Good insight and judgment as patient recognizes that there is a problem and is seeking help + abstinent from EtOH & complying with treatment plan.

A/P Last Updated by THODE,KIRSTIN @ 04 Jan 2011 1810 EST

1. ANXIETY DISORDER NOS: IMPRESSION: 29y/o Caucasian F AD USMC O2 without significant genetic loading for illness or substance use disorders + personal Hx of sexual abuse, bulimia, & alcohol dependence who reports improvement in anxiety & depressive symptoms in the context of fluoxetine titration, individual therapy, continued abstinence from EtOH & decreased occupational stressors. Patient's current chief complaint is sleep disturbance 2/2 ruminations, nightmares, & movements in sleep unresponsive to high-dose hydroxyzine. Current MSE with evidence of stimulus-bound anxiety. Working diagnosis is Anxiety Disorder NOS along with well-established Acohol Dependence & Bulimia by Hx. Differential diagnosis includes PTSD, Generalized Anxiety Disorder, Adjustment Disorder, & Substance-Induced Anxiety Disorder. No current indication of malingering, treatable medical causes of current symptoms, or drug-seeking behaviors. No current or historical evidence of mania or psychosis. As per risk assessment below, patient does not currently represent an imminent threat to self or others.

AXIS I - Anxiety Disorder NOS; Alcohol Dependence in Early Full Remission; Bulimia by Hx
AXIS II - No current diagnosis
AXIS III - Low Mg level by labs
AXIS IV - Occupational stressors
AXIS V - Current GAF = 65

PLAN:
1. Medication - Increase fluoxetine to 60mg PO qAM (dispensed 20mg #90 RF1) to better target anxiety symptoms. Discontinue hydroxyzine 2/2 lack of efficacy. Start prazosin titration (dispensed 1mg #40 RF0) off-label use for anxiety-related sleep disturbance. Discussed risks, benefits, & side effects of medications as well as possibility of no treatment. Patient verbalizes understanding & agrees with plan. She is advised to refrain from alcohol while taking any psychotropic medication.
2. Therapy - Supportive with this provider. Patient to continue individual therapy with Ms. Pia in this clinic. Discussed bibliotherapy with patient.
3. Labs/referral - None indicated at this time. Defer management of brith control & low Mg level to PCM/GYN. Consider repeat electrolyte levels + Mg given Hx of binging-purging.
4. Prevention - Patient encouraged to abstain from EtOH & illicit drugs, continue cutting back on cigarette smoking, & utilize healthy diet & routine cardiovascular exercise. She plans to continue weekly AA meetings + contact with sponsor.
5. Safety - No current indication to add patient to the MH flight High Risk/Interest Log or for inpatient psychiatric hospitalization. Safety plan reviewed. Patient instructed & agrees to report to or call the mental health clinic (240-857-7186) during duty hours or call ER at 240-857-2333 or 911 after hours for thoughts of harming self or others.
6. Disposition - Patient released without additional duty or mobility limitations. Patient to touch base with this provider in person or over the phone in 2 weeks to assess response to low-dose prazosin. Anticipate next formal, scheduled appt with this provider in 4 weeks (TBD after 2-week check-in) with VS & PCL-M. She will to see Ms. Pia for individual therapy as previously scheduled.

This provider met with patient for 45 minutes & >50% of appointment time spent counseling &/or coordinating care.

Procedure(s): -Psychiat Therapy Indiv Appr 45-50 Min W/ Med Eval Managemt x 1
Medication(s): -PRAZOSIN--PO 1MG CAP - TAKE ONE CAP PO QHS FOR 3 DAYS, THEN TAKE TWO CAPS PO QHS, THEN TAKE THREE CAPS PO QHS #40 RF0 Qt: 40 Rf: 0 Ordered By: THODE,KIRSTIN Ordering Provider: THODE, KIRSTIN T
-FLUOXETINE--PO 20MG CAP - T3 CAP PO DAILY #90 RF1 Qt: 90 Rf: 1 Ordered By: THODE,KIRSTIN Ordering Provider: THODE, KIRSTIN T

2. BULIMIA NERVOSA
3. ALCOHOL DEPENDENCE IN REMISSION

Disposition Last Updated by THODE,KIRSTIN @ 04 Jan 2011 1810 EST
Released w/o Limitations
Follow up: 4 week(s) in the PSYCHIATRY MG clinic or sooner if there are problems. - Comments: 2 weeks phone call or brief appt to assess response to prazosin.
Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

04 Jan 2011 1400
Facility: NNMC Bethesda, MD Clinic: PSYCHIATRY MG Provider: THODE,KIRSTIN T

Note Written by THODE,KIRSTIN @ 04 Jan 2011 1454 EST
Additional A/P Information:
Discontinued FLUOXETINE--PO 20MG CAP - T2 CAP PO DAILY #30 RF0

Note Written by THODE,KIRSTIN @ 04 Jan 2011 1455 EST
Suicide / Violence Risk Assessment
Risk Factors: Axis I diagnosis, anxiety, Hx of abuse, Hx of substance dependence, occupational stressors, young, Caucasian.

Protective Factors: No personal or family Hx of suicide attempts, no past psychiatric hospitalizations, no current suicidal ideation/intent/plan, no psychosis, employed, engaged in treatment, future-oriented, female, strong support from husband, spirituality, symptoms have improved.

Category: Baseline

Risk Level: Not elevated.

Signed By THODE, KIRSTIN (Physician, 79th MEDICAL WING, ANDREWS AFB, MD 20762) @ 06 Jan 2011 0915

Patient: **KLAY, ARIANA BEVIN**
Treatment Facility: **779TH MEDICAL GROUP**
Patient Status: **Outpatient**

Date: **22 Dec 2010 0849 EST**
Clinic: **SOCIAL WORK MG**

Appt Type: **T-CON***
Provider: **PIACQUADIO,MICHELLE A**

Call Back Phone: **(703)-389-4046**

Reason for Telephone Consult: Contacted pt regarding today's missed appt.

AutoCites Refreshed by PIACQUADIO,MICHELLE A @ 22 Dec 2010 0849 EST

Problems
Chronic:
- Bulimia nervosa
- Alcohol dependence in remission
- Anxiety disorder NOS
- Major depression, single episode
- Inquiry and counseling
- Patient education
- Patient education about a proper diet
- Insomnia
- Alcoholism
- Visit for: administrative purposes
- Compression arthralgia of the knee / patella / tibia / fibula

Family History
- Family medical history (General FHx)
- Of mental illness (not retardation) (General FHx)
- Of substance abuse (General FHx)

Allergies
- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
HYDROXYZINE HCL, 25 MG, TABLET, ORAL	Active	T2-3 TB PO QHS PRN INSOMNIA #90 RF0	NR	01 Dec 2010
FLUOXETINE HCL, 20 MG, CAPSULE, ORAL	Active	T2 CAP PO DAILY #60 RF1	1 of 1	01 Dec 2010
Ethinyl Estradiol 0.02mg + Drospirenone 3mg, Tablet, Oral, 28 Day Dose Pack	Refill	TAKE 1 TAB PO QD CONSECUTIVE X 63 DAYS #6 RF3	1 of 2	05 Nov 2010

LMP: 15 Jun 2010. Date Basis: unknown.

SO Note Written by PIACQUADIO,MICHELLE A @ 22 Dec 2010 0851 EST
Subjective
Pt apologized for missing this morning's appt. She is leaving for London tomorrow for the holidays and denied any safety concerns. She will call to reschedule appt for the week of 3 Jan.

A/P Last Updated by PIACQUADIO,MICHELLE A @ 22 Dec 2010 0851 EST
1. Anxiety disorder NOS

Disposition Last Updated by PIACQUADIO,MICHELLE A @ 22 Dec 2010 0851 EST

Signed By PIACQUADIO, MICHELLE A (Physician/Workstation) @ 22 Dec 2010 0851

MAP

Version LDB: 04 Jun 09

DATE: 10 Dec 2010; **DURATION**: 75 min; **Service Provided:** Individual therapy/90808;
SUBJECTIVE: Pt is a 29-yr-old, married, Caucasian female. She is a Marine, 1LT, stationed at Henderson Hall. Pt was referred for individual therapy by Major Morganstein from MGMC Addiction Services. Pt reports symptoms of anxiety connected to unresolved feelings/thoughts related to previous sexual harassment/assault. Treatment is individual therapy with emphasis on Prolonged Exposure Therapy and a primary treatment goal of: decreasing anxiety, building self esteem, decreasing PTSD-like symptoms associated with the unresolved trauma and resolving any underlying contributing factors related to her symptoms.
PROGRESS:
Pt reported that she has been applying for graduate school in Social Work and feels good about this decision. This is giving her a focus "whether she stays in MC or has to get out". Pt realizes that she has continued recovery work to accomplish prior to engaging in this academic program. Pt reports that since she stopped drinking, her bulimic behaviors have returned. She reports bingeing/vomiting 5 times in past month. Clinician addressed some basic steps to take towards stopping bulimic behaviors, and will continue to discuss in future sessions. Clinician recommends addressing this issue before engaging in Prolonged Exposure Therapy for trauma recovery. Lastly pt reports continued unresolved pain related to trauma that continues to manifest in anxiety and emotional pain.
-New information for pt's medical provider(s): Pt will continue to see Dr. Thode for psychotropic medication management.
********Due to patient privacy concerns, more complete documentation is kept in separate Mental Health record. *******

SESSION SUMMARY: *Pt shared that husband found her purging and requested that she address this in her counseling, and she agreed. She reports that vomiting is relieving. She reports that she and husband had friends over to their house from her last command. They are aware of what she experienced related to harassment and were supportive. Pt found herself crying and was embarrassed in front of her friends.*
Homework/Results: N/A
PAIN: Not reported or indicated.
Outcome Measures, Monitoring Measures: NA

OBJECTIVE: Mental Status Exam:
Overall: - No unusual or noteworthy change from previously documented MMSE, e.g., appearance, orientation, behavior, interpersonal relatedness, speech patterns, thought content, etc.
MOOD: Feels more hopeful and improved, but mood is often anxious and sad related to trauma;
SLEEP: Difficulty falling asleep;
APPETITE: No problems reported; (more information is needed to discern whether pt knows the difference between emotional and physical hunger);
ENERGY: Low related to sleep problems;
CONCENTRATION: "Better";
LIBIDO: "Low";
INTERESTS: Just completed GREs and scored high; is also paying soccer;
SI: Denied SI
HI: Denied HI
RISK LEVEL (SI/HI): Minimal

ASSESSMENT:
Axis I – *Anxiety Disorder NOS – 300.00 per hx*
Alcohol Dependency in early full remission – per hx

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
MGMC	**AD**	**USAF**	
SPONSOR'S NAME	UNIT	RELATIONSHIP TO SPONSOR	

PATIENTS IDENTIFICATION:	WORK PHONE	HOME PHONE
LAST_NAME, First, Klay, Ariana B **SS#: 20/532-94-8850** **DOB: 07 Jan 1981** **DATE SEEN: 10 Dec 2010**		

Version LDB: 04 Jun 09

DATE: 1 Dec 2010; **DURATION**: 60 min; **Service Provided:** Individual therapy/90806;
SUBJECTIVE: Pt is a 29-yr-old, married, Caucasian female. She is a Marine, 1LT, stationed at Henderson Hall. Pt was referred for individual therapy by Major Morganstein from MGMC Addiction Services. Pt reports symptoms of anxiety connected to unresolved feelings/thoughts related to previous sexual harassment/assault. Treatment is individual therapy with emphasis on Prolonged Exposure Therapy and a primary treatment goal of: decreasing anxiety, building self esteem, decreasing PTSD-like symptoms associated with the unresolved trauma and resolving any underlying contributing factors related to her symptoms.
PROGRESS:
-Overall, pt is responding to treatment: WNL. Pt reports feeling better overall about having started therapy and having an outlet to discuss her traumas. She is also feeling good about her ongoing sobriety and support system through AA. She feels a great deal of support from her new command. She does report anxiety in social situations, particularly fearing that she will have to discuss issues related the sexual traumas. She reports continued problems with sleep due to ruminating about the traumas. She reports feeling depressed and reclusive, and worries that she will never be able to trust again based on traumas she experienced.
-New information for pt's medical provider(s): Pt will discuss her psychotropic medication regimen with Dr. Thode after today's therapy session.
******Due to patient privacy concerns, more complete documentation is kept in separate Mental Health record.** *****

SESSION SUMMARY: *Pt shared more details related to sexual harassment and sexual assault. She discussed how she is coping and what she is doing to get through. She also reported an ongoing investigation occurring about someone in her previous command and shared how she felt about being asked questions by the investigator and what this triggered in her regarding her traumas. She reported feeling some validation by investigator regarding what she went through in previous command.*
Homework/Results: N/A
PAIN: Not reported or indicated.
Outcome Measures, Monitoring Measures: NA

OBJECTIVE: Mental Status Exam:
Overall: - No unusual or noteworthy change from previously documented MMSE, e.g., appearance, orientation, behavior, interpersonal relatedness, speech patterns, thought content, etc.
MOOD: Improved overall; anxious/tearful when discussing traumas; feels angry that no one in previous command will acknowledge the sexual harassment she experienced;
SLEEP: Difficulty falling asleep;
APPETITE: No problems reported;
ENERGY: No problems reported;
CONCENTRATION: "Low";
LIBIDO: "Low";
INTERESTS: Studying for GRE and playing soccer;
SI: Denied SI
HI: Denied HI
RISK LEVEL (SI/HI): Minimal

ASSESSMENT:
Axis I – *Anxiety Disorder NOS – 300.00 per hx*
Alcohol Dependency in early full remission – per hx

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
MGMC	**AD**	**USAF**	
SPONSOR'S NAME	UNIT	RELATIONSHIP TO SPONSOR	

PATIENTS IDENTIFICATION:	WORK PHONE	HOME PHONE
LAST_NAME, First, Klay, Ariana B **SS#: 20/532-94-8850** **DOB: 07 Jan 1981** **DATE SEEN: 1 Dec 2010**		

Bulimia Nervosa – per hx
R/O PTSD; R/O Depressive Disorder NOS

Axis II – Deferred – 799.9
Axis III – Low Mg level by labs

PLAN: Pt to return to MHC for individual therapy on a weekly basis
HIGH RISK LOG: No
SAFETY PLAN: Reviewed with pt emergency procedures and phone numbers (MHC 857-7186 during duty hours, ER 857-2333).

DISPOSITION: Pt returned to duty with no limitations
PROFILE/ LIMITATIONS:
-Sensitive Duties: SC
-Profile: No MH
-PCS: Yes
-Deployable: Yes
-Unit notification (if urgent limitations): NA

DETAILS TX PLAN: *begin to identify what she needs/wants to resolve regarding sexual harassment/assault*
Homework: *Read 2 chapters regarding Prolonged Exposure*
Referrals: None

P: PREVENTION / EDUCATION: Pt encouraged to make healthy lifestyle choices such as: healthy thinking, regular sleep/rest, nutrition, exercise, socializing, family time, couple time, recreations, stress mgt to help prevent exacerbation of symptoms. Pt indicated understanding of above.

EDUCATION MATERIALS: Chapters on Prolonged Exposure Therapy

MAPiacquadio, LCSW

Michelle A. Piacquadio, ACSW, LCSW
Licensed Clinical Social Worker, Civ Contractor
Mental Health Clinic, MGMC
Andrews AFB

Patient: **KLAY, ARIANA BEVIN**
Treatment Facility: **779TH MEDICAL GROUP**
Patient Status: **Outpatient**

Date: **15 Nov 2010 1430 EST**
Clinic: **SOCIAL WORK MG**

Appt Type: **EST**
Provider: **PIACQUADIO,MICHELLE A**

Reason for Appointment: extend to 90 min
Appointment Comments:
orc

AutoCites Refreshed by PIACQUADIO,MICHELLE A @ 15 Nov 2010 1732 EST

Problems
Chronic:
- Bulimia nervosa
- Alcohol dependence in remission
- Anxiety disorder NOS
- Major depression, single episode
- Inquiry and counseling
- Patient education
- Patient education about a proper diet
- Insomnia
- Alcoholism
- Visit for: administrative purposes
- Compression arthralgia of the knee / patella / tibia / fibula

Family History
- Family medical history (General FHx)
- Mental illness (not retardation) (General FHx)
- Substance abuse (General FHx)

Allergies
- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
Ethinyl Estradiol 0.02mg + Drospirenone 3mg, Tablet, Oral, 28 Day Dose Pack	Refill	TAKE 1 TAB PO QD CONSECUTIVE X 63 DAYS #6 RF3	1 of 2	05 Nov 2010
HYDROXYZINE HCL, 25 MG, TABLET, ORAL	Active	TAKE 1-2 TABS AS NEEDED BEFORE BEDTIME FOR SLEEP #60 RF0	NR	28 Oct 2010
FLUOXETINE HCL, 20 MG, CAPSULE, ORAL	Active	T1 CAP PO DAILY #30 RF0	NR	28 Oct 2010
MAGNESIUM OXIDE, 400 MG, TABLET, ORAL	Active	TAKE ONE TAB PO BID #60 RF0	NR	28 Oct 2010
Folic Acid + Ferrous Fumarate + Prenatal Vitamin, (Prenatal Plus), Tablet, Oral	Active	T 1 TAB PO DAILY	NR	22 Sep 2010

LMP: 15 Jun 2010. Date Basis: unknown.

SO Note Written by PIACQUADIO,MICHELLE A @ 02 Dec 2010 1516 EST
Reason for Visit

Visit for: DATE: 15 Nov 2010; DURATION: 90 min; Service Provided: Diagnostic Intake Evaluation/90801;

SUBJECTIVE: Pt is a 29-yr-old, married, Caucasian female. She is a Marine, 1LT, stationed at Henderson Hall. Pt was referred for individual therapy by Major Morganstein from MGMC Addiction Services. Patient seen voluntarily in the Mental Health Clinic for initial intake evaluation which included: reviewed pt's symptoms, stressors/problems, conducted comprehensive history.

-Reviewed with pt limits of confidentiality, MH records vs. medical records, addressed questions regarding confidentiality.

Chief complaint/Brief Summary: Pt describes PTSD-like symptoms and depression related to recent history of sexual harassment and sexual assault. Pt describes severe sexual harassment at previous command that resulted in unresolved emotional pain, anxiety and depressed mood.

She also used alcohol to cope. She reports experiencing sexual assault this past year while under the influence. She feared reporting the sexual harassment due to embarrassment, but "when lies were spread about her, she was unable to cope and slapped a Marine who was berating her in public regarding these lies". This resulted in non judicial punishment by her superior and an investigation was ordered by him when pt shared the sexual harassment. Pt is concerned about how this could impact her career and the potential for discharge from MC. Pt reports problems with sleep, loss of sex drive, racing thoughts, low concentration, no enjoyment, headaches and heart pounding at times. Pt comes to therapy to resolve these issues and also to address any unresolved issues from childhood regarding sexual abuse. She continues in AA to address alcohol dependence. She also has a diagnosis of Bulimia Nervosa per hx with denial of binge-purge cycle since college many years ago, however continues to struggle with poor body image. Pt scored 70 (50= clinical range) on PLC-M - inventory to assess PTSD.

15 Nov 2010 1528

Facility: NNMC Bethesda, MD Clinic: SOCIAL WORK MG Provider: PIACQUADIO,MICHELLE A

Brief Summary of Medical / MH TX history / Substance use/abuse/TX history for pt's medical provider(s): Pt reports hx of 3 therapy sessions for bulimia; 3 marital sessions and tx at Intensive Addictions Services at MGMC as a treatment success from 9 Sep 2010 to 20 Oct 2010. Pt is also seeing Dr. Thode at MHC for psychotropic medication management.

Pain is a significant issue for pt - she reports that she has daily pain of back or knee pain and sometimes headaches.

******Due to patient privacy concerns, more complete documentation is kept in separate Mental Health record. *****.

Objective

MOOD: Pt reports that overall mood has improved somewhat since completing tx at IAS and remaining sober. However, she continues to be anxious and depressed particularly related to sexual harassment.
Mood Problems began 5 months ago;
AFFECT: Congruent; appropriately tearful at times;
SLEEP: Insomnia; recently prescribed Hydroxyzine for sleep aid;
INTEREST: Sometimes lacks interest;
GUILT/WORTHLESSNESS: Sometimes;
ENERGY: Denies problems;
CONCENTRATION/ATTENTION: Decreased;
APPETITE: Denied problems;
WEIGHT: Body image issues; no weight problems reported;
LIBIDO: Decreased overall;
IRRITABILITY / ANGER: continues to be an issue;
ORIENTATION: Alert and Oriented x 4.
BEHAVIOR/RELATEDNESS: Pt was cooperative, pleasant and attentive, hygiene WNL.
ATTITUDE: receptive to new ideas and feedback; strong need to share details of sexual harassment and assault; responds well to validation and normalization;
THOUGHT CONTENT: WNL, No Psychotic SxS;
THOUGHT PROCESS: Logical & linear, Goal-directed. Coherent;
EYE CONTACT: Appropriate.
SPEECH: Overall, WNL for rate, volume, production & prosody.
JUDGMENT: WNL/intact;
INSIGHT: WNL/intact;
PSYCHOMOTOR: WNL,
SI: Denied SI, no history of attempts/self-harm. SUICIDAL RISK: Minimal
HI: Denied HI. HOMICIDAL RISK: Minimal ~OUTCOME MEASURE or PSYCH TESTING: completed on 28 Oct 2010 OQ45.2 completed, SD=51 (above 36 indicating possible clinical level concerns); IR=20 (above 15 indicating possible clinical level concerns), SR=17 (above 12 indicating possible clinical concern), Tot=88 (above 63 indicating possible clinical concerns). Critical Items reviewed: #8="Never", #32="Sometimes" - related to hx of alcohol dependency, bit remains sober", #44="Rarely" - irritable and distressed but denies any intention of harming anyone or self

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A/P Written by PIACQUADIO,MICHELLE A @ 02 Dec 2010 1521 EST

1. ANXIETY DISORDER NOS: Axis I - Anxiety Disorder NOS per hx - 300.00
Alcohol Dependence in Early Full Remission - per hx
Bulimia Nervosa - per hx
R/O PTSD; R/O Depressive Disorder NOS
Axis II - Deferred - 799.9
Axis III - Hx low Mg level per labs
Axis IV - Stressors: Occupational/Relational
Axis V - GAF now = 65

DISPOSITION:
PLAN:
-Discussed with pt nature and type of treatment, treatment alternatives, potential risks and benefits of treatment, risks of not receiving treatment, likelihood of achieving treatment goals.
-Treatment Recommended: Individual therapy recommended with continued AA and psychotropic medication management.
-Anticipated length of treatment: approximately 20 weeks or sessions.
-Primary Focus of TX: to reduce anxiety and resolve symptoms related to trauma; remain sober; build self-esteem and confidence;
-Pt Consent / Understanding: Pt verbalized understanding of and agreed to plan
--Discussed with patient 24 hour on-call/Emergency services
--HIGH RISK LOG: Patient was not placed on HIGH RISK LOG.
Referrals: None

Procedure(s): -Psychiatric Evaluation Comprehensive Examination x 1