Patient: **CHAJI, HOUDA**
Treatment Facility: **COMMUNITY MENTAL HEALTH SERVICE FT. IRWIN**
Patient Status: **Outpatient**

Date: **04 Apr 2011 1030 PDT**
Clinic: **PSYCHIATRY WACH**

Appt Type: **EST**
Provider: **JOHNSON,DAVID E**

Reason for Appointment: F/U
Appointment Comments:
scm31mar

A/P Written by JOHNSON,DAVID E @ 04 Apr 2011 1522 PDT
1. POST-TRAUMATIC STRESS DISORDER
Procedure(s): -Psychoactive Medication Management x 1

Disposition Written by JOHNSON,DAVID E @ 04 Apr 2011 1522 PDT
Released w/o Limitations

Note Written by JOHNSON,DAVID E @ 04 Apr 2011 1522 PDT

Weed MEDDAC Behavioral Health Department Followup

The patient's identity was verified via full name and date of birth.

ID
30 yo married female DEP with PTSD.
Subjective
Pt was calmer and collected today. She took the Seroquel and said it worked well. It turned out her husband was at training, not deployed, and he returned this weekend. She restarted the Prozac. We discussed last week's issue briefly; she has mainly been isolating in her house. She is going to the dental clinic this week to finish up her hours there.

I told the pt I am deploying soon and will see her one more time in 3 weeks. We processed this and she expressed discomfort with building trust with a new person.
MEDS
Prozac 40 mg daily
Seroquel 25 mg at bedtime

Not refilled yet: Prazosin 6 mg at bedtime
PAIN
No pain issues noted. Pain is 0 out of 10 today.
MSE
Appearance: appropriately dressed and groomed.
Movement: no psychomotor retardation or agitation
Eye Contact: fair
Speech Rate/Volume: normal tone; normal rate.
Interaction with Examiner: calm, smiling
Mood: calm
Affect: constricted and pleasant
Judgment: fair
Insight: fair
Thought Processes: Linear, logical, goal-directed
Thought Content:
No AH/VH/delusions.

SI: no thoughts, plan, or intent

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HI: none

ASSESSMENT

Suicide risk was assessed as low.
Protective factors included no SI, no hopelessness, no h/o suicide attempts, husband's presence
Risk factors included anxiety and fear, marital tension

DIAGNOSIS

Axis I Posttraumatic stress disorder
Axis II deferred
Axis III none
Axis IV sexual assault
Axis V GAF 63

PLAN:

Prozac 40 mg daily.
Seroquel 25 mg at bedtime

F/U with MAJ Eason for therapy

Patient was seen for 10 minutes.

Med reconciliation completed.

Signed By JOHNSON, DAVID E (Psychiatrist, Schweinfurt Behavioral Health Clinic) @ 04 Apr 2011 1522

CHRONOLOGICAL RECORD OF MEDICAL CARE
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STANDARD FORM 600 (REV. 5)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

Patient: **CHAJI, HOUDA**
Treatment Facility: **COMMUNITY MENTAL HEALTH SERVICE FT. IRWIN**
Patient Status: **Outpatient**

Date: **31 Mar 2011 1636 PDT**
Clinic: **PSYCHIATRY WACH**

Appt Type: **ACUT**
Provider: **JOHNSON,DAVID E**

Reason for Appointment: acute

A/P Written by JOHNSON,DAVID E @ 31 Mar 2011 1647 PDT
1. POST-TRAUMATIC STRESS DISORDER
Procedure(s): -Psychiat Therapy Indiv Appr 20-30 Min W/ Med Eval Managemt x 1

Disposition Written by JOHNSON,DAVID E @ 31 Mar 2011 1647 PDT
Released w/o Limitations

Note Written by JOHNSON,DAVID E @ 31 Mar 2011 1647 PDT
.

Weed MEDDAC Behavioral Health Department Followup

The patient's identity was verified via full name and date of birth.

ID
30 yo married female DEP with PTSD.
Subjective
Pt was referred for med refill from her SW appt today but was crying despondently in the waiting room so she was seen as a walk in. Pt related events at CID where she received a polygraph. She was nervous about being made to sit in a corner facing away, and when asked said she did not trust the polygrapher. She says she was told she "failed" the test because of that answer and was accused of keeping some money ($6000) given to her for safeguarding by the wife of the man who allegedly raped her. We processed how the legal system and investigative process worked. Pt agrees to take a sleep pill tonight and will see me on Monday. She contracted for safety and would not hurt herself due to her children. Her husband is deployed now.
MEDS
Prozac 40 mg daily
Seroquel 25 mg at bedtime

Not refilled yet: Prazosin 6 mg at bedtime
PAIN
No pain issues noted. Pain is 0 out of 10 today.
MSE
Appearance: appropriately dressed and groomed.
Movement: no psychomotor retardation or agitation
Eye Contact: poor
Speech Rate/Volume: loud tone; normal rate.
Interaction with Examiner: crying, blaming herself
Mood: dysphoric
Affect: labile
Judgment: fair
Insight: fair
Thought Processes: Linear, logical, goal-directed
Thought Content:
No AH/VH/delusions.

SI: no thoughts, plan, or intent
HI: none

Name/SSN:	**CHAJI, HOUDA**	Sex:	F	Sponsor/SSN:	BELKHATIR, KHALID/
FMP/SSN:		Tel H:		Rank:	SPECIALIST
DOB:	**08 Apr 1980**	Tel W:		Unit:	WJTEAA (0051 SC CO 51ST INT TRANS)
PCat:	A41 USA FAM MBR AD	CS:		Outpt Rec. Rm:	
MC Status:		Status:		PCM:	ROBERTS,MICAH J
Insurance:	No			Tel. PCM:	

CHRONOLOGICAL RECORD OF MEDICAL CARE
THIS INFORMATION IS PROTECTED BY THE PRIVACY ACT OF 1974 (PL-93-579). UNAUTHORIZED ACCESS TO THIS INFORMATION IS A VIOLATION OF FEDERAL LAW. VIOLATORS WILL BE PROSECUTED.

STANDARD FORM 600 (REV. 5)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

ASSESSMENT

Pt with acute stressor; pt agrees to take some time to relax and recuperate from the experience. Pt agrees to take a sleeping med tonight despite past fears of her children's safety if she is asleep. F/U next week.

Suicide risk was assessed as low.
Protective factors included no SI, no hopelessness, no h/o suicide attempts, husband's presence
Risk factors included anxiety and fear, marital tension

DIAGNOSIS

Axis I Posttraumatic stress disorder
Axis II deferred
Axis III none
Axis IV sexual assault
Axis V GAF 63

PLAN:

Prozac 40 mg daily.
Seroquel 25 mg at bedtime

Prazosin 6 mg at bedtime.
F/U with MAJ Eason for therapy

Patient was seen for 30 minutes.

Follow up Monday.

Med reconciliation completed. Pt given list of current meds.

Signed By JOHNSON, DAVID E (Psychiatrist, Schweinfurt Behavioral Health Clinic) @ 31 Mar 2011 1647

Name/SSN:	CHAJI, HOUDA	Sex:	F	Sponsor/SSN:	BELKHATIR, KHALID/
FMP/SSN:		Tel H:		Rank:	SPECIALIST
DOB:	08 Apr 1980	Tel W:		Unit:	WJTEAA (0051 SC CO 51ST INT TRANS)
PCat:	A41 USA FAM MBR AD	CS:		Outpt Rec. Rm:	
MC Status:		Status:		PCM:	ROBERTS,MICAH J
Insurance:	No			Tel. PCM:	

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Patient: **CHAJI, HOUDA**
Treatment Facility: **WEED ACH**
Patient Status: **Outpatient**

Date: **23 Mar 2011 1300 PDT**
Clinic: **SOCIAL WORK WACH**

Appt Type: **EST**
Provider: **EASON,DEBORAH L**

Reason for Appointment: F/U
Appointment Comments:
scm15mar

AutoCites Refreshed by EASON,DEBORAH @ 23 Mar 2011 1304 PDT

Problems

Chronic:

- Visit for: screening for pulmonary tuberculosis
- Post-traumatic stress disorder
- Visit for: administrative purposes
- Visit for: screening exam
- Recent weight gain
- General counseling on contraception
- Cervical Pap smear
- Insomnia
- Gastroenteritis
- Xerosis cutis

Allergies

- No Known Allergies

SO Note Written by EASON,DEBORAH L @ 28 Mar 2011 1259 PDT

Chief complaint

The Chief Complaint is: Depression and anxiety.

Reason for Visit

Visit for: 30 yo female family member presented to the Behavioral Health Clinic for individual counseling session. Referred by:

[X] Other: Sexual Assault Response Coordinator.

History of present illness

The Patient is a 30 year old female. Source of patient information was patient. Reliability of source of patient information was good.

No marital problems.

Personal history

Social history reviewed.
Personal history: Chronic emotional stress.
Behavioral history: No tobacco use.
Alcohol: No consumption of alcohol.
Home environment: Native language Arabic.
Financial status: Financial status is secure.
Marital: Currently married 10 years with daughter and son.
Functional status: Lack of social support from friends.

Subjective

Completed by patient:
Consent to Treatment: [X] YES
Limits of Confidentiality: [X] YES
Privacy Act: [X] YES.

Review of systems

Psychological symptoms: No racing thoughts.

Physical findings

Vital signs:

- Pain level (0-10) 0.

General appearance:

° Normal. ° Awake. ° Alert. ° Oriented to time, place, and person.

Neurological:

- Memory was impaired. ° Level of consciousness was normal. ° No decrease in concentrating ability was observed. ° Cognitive functioning was normal. ° No confusion was observed. ° No delirium was noted. ° No disorientation was observed.

Speech: ° Normal.

Psychiatric Exam:

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28 Mar 2011 1252
Facility: Weed ACH Fort Irwin, CA   Clinic: SOCIAL WORK WACH   Provider: EASON,DEBORAH L

Appearance: ° Normal. ° Clothing was appropriate. ° Grooming was normal.
Demonstrated Behavior: ° No decreased eye-to-eye contact was observed.
Attitude: ° Showed no inability to engage. ° Not guarded. ° Cooperative. ° Not uncommunicative.
Mood: ° Euthymic.
Affect: ° Congruent with the mood.
Thought Processes: • Racing thoughts were demonstrated. ° Not impaired.
Thought Content: ° Revealed no impairment. ° No obsessions. ° No paranoid ideations. ° No delusions. ° No suicidal tendency. ° No suicidal ideation. ° No suicidal plans. ° No suicidal intent. ° No homicidal tendencies. ° No homicidal ideations. ° No homicidal plans. ° No homicidal intent.

Spiritual assessment:
• Faith provides strength and comfort.

Objective
30 y/o female family member presented to the Behavioral Health Clinic for individual counseling session. Patient currently in a happy mood, alert and oriented x3, groomed appropriately and dressed neatly in civilian clothing. Presently, patient reports increase of insomnia and nightmares with dreams of blood and knives. Patient acknowledged her husband will soon be deploying (this week) and she is apprehensive regarding her safety in the absence of her husband. Patient has determined if her alleged perpetrator is not incarcerated she will most likely return to Georgia and reside with her brother and his family until her husband returns from deployment. Patient states she would rather remain at Fort Irwin but would feel unsafe if the perpetrator is found not guilty of her rape. Provider discussed medication compliance and stress management techniques with patient. Patient reports she is currently out of her psychiatric medications. Provider encouraged patient to contact her psychiatrist and request a refill. Patient informed this will be last session with writer. Patient agreeable to continue CBT with another BH provider. Patient scheduled with CPT Sheaffer (BH psychologist) for follow up and continued treatment. Duration of this session: 50 minutes.
Current treatment plan entails:
1. Increase patients understanding of depression/anxiety through patient education
2. Decrease symptoms of depression/ anxiety via CBT and supportive counseling
3. Improve mood, sleep and energy with relaxation techniques
4. Increase awareness of coping skills through patient education
5. Increase self confidence utilizing CBT

.

A/P Written by EASON,DEBORAH @ 28 Mar 2011 1258 PDT
1. POST-TRAUMATIC STRESS DISORDER
Procedure(s): -Social Work Individual Outpatient Counseling 45-50 Minutes x 1

Disposition Written by EASON,DEBORAH @ 28 Mar 2011 1259 PDT
Released w/o Limitations
Follow up: with PCM and/or in the MENTAL HEALTH WACH clinic. - Comments: Currently, 30 yo female family member denies SI/HI and self-harm. Provider verbally contracted with patient to visit BH, report to the ED or contact 911 if she feels she will harm herself or others. Patient acknowledged agreement and understanding of the above contract for safety.

Suicide Risk Assessment Scale (SAD PERSONS SCALE)

S - Sex: 0
A - Age: 0
D - Depression: X
P - Previous attempt: 0
E - Ethanol abuse: 0
R - Rational thinking loss: 0
S - Social Supports Lacking: 0
O - Organized Plan: 0
N - No Spouse: 0
S - Sickness: 0

Total: 1

The presence of each risk factor is assigned a point of 1. Higher scores indicate greater patient suicide risk.

0 -1 Minimal Risk
2-3 Low Risk
4-5 Moderate Risk
6-7 High Risk
8-11 Imminent Risk

Name/SSN:	**CHAJI, HOUDA**	Sex:	F	Sponsor/SSN:	BELKHATIR, KHALID
FMP/SSN:		Tel H:		Rank:	SPECIALIST
DOB:	**08 Apr 1980**	Tel W:		Unit:	WJTEAA (0051 SC CO 51ST INT TRANS)
PCat:	A41 USA FAM MBR AD	CS:		Outpt Rec. Rm:	
MC Status:		Status:		PCM:	ROBERTS,MICAH J
Insurance:	No			Tel. PCM:	

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23 Mar 2011 1252

Facility: Weed ACH Fort Irwin, CA Clinic: SOCIAL WORK WACH Provider: EASON,DEBORAH L

Overall Risk of Self-Harm (or harm to others): MIN risk at this time.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By EASON, DEBORAH (LCSW, BCD, Womack Army Medical Center, Department of Social Work) @ 28 Mar 2011 1316

Name/SSN:	**CHAJI, HOUDA**	Sex: F	Sponsor/SSN:	BELKHATIR, KHALID/	
FMP/SSN:		Tel H:	Rank:	SPECIALIST	
DOB:	**08 Apr 1980**	Tel W:	Unit:	WJTEAA (0051 SC CO	51ST INT TRANS)
PCat:	A41 USA FAM MBR AD	CS:	Outpt Rec. Rm:		
MC Status:		Status:	PCM:	ROBERTS,MICAH J	
Insurance:	No		Tel. PCM:		

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Patient: **CHAJI, HOUDA**
Treatment Facility: **WEED ACH**
Patient Status: **Outpatient**

Date: **02 Mar 2011 1100 PDT**
Clinic: **SOCIAL WORK WACH**

Appt Type: **EST**
Provider: **EASON,DEBORAH L**

Reason for Appointment: F/U
Appointment Comments:
scm24feb

AutoCites Refreshed by EASON,DEBORAH @ 02 Mar 2011 1115 PDT

Problems

Chronic:

- Visit for: screening for pulmonary tuberculosis
- Post-traumatic stress disorder
- Visit for: administrative purposes
- Visit for: screening exam
- Recent weight gain
- General counseling on contraception
- Cervical Pap smear
- Insomnia
- Gastroenteritis
- Xerosis cutis

Allergies

- No Known Allergies

SO Note Written by EASON,DEBORAH L @ 07 Mar 2011 1734 PDT

Chief complaint

The Chief Complaint is: Depression and anxiety.

Reason for Visit

Visit for: 30 yo female family member presented to the Behavioral Health Clinic for individual counseling session. Referred by:

[X] Other: Sexual Assault Response Coordinator.

History of present illness

The Patient is a 30 year old female. Source of patient information was patient. Reliability of source of patient information was good.

No marital problems.

Personal history

Social history reviewed.
Personal history: Chronic emotional stress.
Behavioral history: No tobacco use.
Alcohol: No consumption of alcohol.
Home environment: Native language Arabic.
Financial status: Financial status is secure.
Marital: Currently married 10 years with daughter and son.
Functional status: Lack of social support from friends.

Subjective

Completed by patient:
Consent to Treatment: [X] YES
Limits of Confidentiality: [X] YES
Privacy Act: [X] YES.

Review of systems

Psychological symptoms: No racing thoughts.

Physical findings

Vital signs:

- Pain level (0-10) 0.

General appearance:

° Normal. ° Awake. ° Alert. ° Oriented to time, place, and person.

Neurological:

- Memory was impaired. ° Level of consciousness was normal. ° No decrease in concentrating ability was observed. ° Cognitive functioning was normal. ° No confusion was observed. ° No delirium was noted. ° No disorientation was observed.

Speech: ° Normal.

Psychiatric Exam:

Name/SSN:	CHAJI, HOUDA	Sex:	F	Sponsor/SSN:	BELKHATIR, KHALID/
FMP/SSN:		Tel H:		Rank:	SPECIALIST
DOB:	08 Apr 1980	Tel W:		Unit:	WJTEAA (0051 SC CO 51ST INT TRANS)
PCat:	A41 USA FAM MBR AD	CS:		Outpt Rec. Rm:	
MC Status:		Status:		PCM:	ROBERTS,MICAH J
Insurance:	No			Tel. PCM:	

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Appearance: ° Normal. ° Clothing was appropriate. ° Grooming was normal.
Demonstrated Behavior: ° No decreased eye-to-eye contact was observed.
Attitude: ° Showed no inability to engage. ° Not guarded. ° Cooperative. ° Not uncommunicative.
Mood: ° Euthymic.
Affect: ° Congruent with the mood.
Thought Processes: • Racing thoughts were demonstrated. ° Not impaired.
Thought Content: ° Revealed no impairment. ° No obsessions. ° No paranoid ideations. ° No delusions. ° No suicidal tendency. ° No suicidal ideation. ° No suicidal plans. ° No suicidal intent. ° No homicidal tendencies. ° No homicidal ideations. ° No homicidal plans. ° No homicidal intent.

Spiritual assessment:

• Faith provides strength and comfort.

Objective

30 y/o female family member presented to the Behavioral Health Clinic for follow up counseling session. Patient currently in a happy mood, alert and oriented x3, groomed appropriately and dressed neatly in civilian clothing. Presently, patient reports decrease in anxiety/depression and reports she is currently taking her psychiatric medications as prescribed. Patient reports she has improved drastically since last session (no longer tearful/anxious) and has become stronger. Patient reports she will continue to fight for justice in court against her perpetrator. Patient voiced this ordeal has taken a toll on her personality as she now finds it difficult to trust and communication. Provider will continue to follow patient and provide CBT and supportive counseling. Patient is scheduled to follow up with Behavioral Health on 2 March 2011 @ 1000.

A/P Written by EASON,DEBORAH @ 07 Mar 2011 0919 PDT

1. POST-TRAUMATIC STRESS DISORDER

Procedure(s): -Social Work Individual Outpatient Counseling 45-50 Minutes x 1

Disposition Written by EASON,DEBORAH @ 07 Mar 2011 0932 PDT

Released w/o Limitations

Follow up: with PCM and/or in the MENTAL HEALTH WACH clinic. - Comments: Currently, 30 yo female family member denies SI/HI and self-harm. Provider verbally contracted with patient to visit BH, report to the ED or contact 911 if she feels she will harm herself or others. Patient acknowledged agreement and understanding of the above contract for safety. Patient to follow up with Behavioral Health on 7 March 2011 @ 0900 for continued CBT and supportive counseling. Duration of this session: 50 minutes.

Suicide Risk Assessment Scale (SAD PERSONS SCALE)

S - Sex: 0
A - Age: 0
D - Depression: X
P - Previous attempt: 0
E - Ethanol abuse: 0
R - Rational thinking loss: 0
S - Social Supports Lacking: 0
O - Organized Plan: 0
N - No Spouse: 0
S - Sickness: 0

Total: 1

The presence of each risk factor is assigned a point of 1. Higher scores indicate greater patient suicide risk.

0 -1 Minimal Risk
2-3 Low Risk
4-5 Moderate Risk
6-7 High Risk
8-11 Imminent Risk

Overall Risk of Self-Harm (or harm to others): MIN risk at this time.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Name/SSN:	CHAJI, HOUDA	Sex:	F	Sponsor/SSN:	BELKHATIR, KHALID/
FMP/SSN:	,	Tel H:		Rank:	SPECIALIST
DOB:	08 Apr 1980	Tel W:		Unit:	WJTEAA (0051 SC CO 51ST INT TRANS)
PCat:	A41 USA FAM MBR AD	CS:		Outpt Rec. Rm:	
MC Status:		Status:		PCM:	ROBERTS,MICAH J
Insurance:	No			Tel. PCM:	

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02 Mar 2011 1101

Facility: Weed ACH Fort Irwin, CA Clinic: SOCIAL WORK WACH Provider: EASON,DEBORAH L

Signed By EASON, DEBORAH (LCSW, BCD, Womack Army Medical Center, Department of Social Work) @ 07 Mar 2011 1736

Name/SSN:	**CHAJI, HOUDA**	Sex:	F	Sponsor/SSN:	BELKHATIR, KHALID/
FMP/SSN:		Tel H:		Rank:	SPECIALIST
DOB:	**08 Apr 1980**	Tel W:		Unit:	WJTEAA (0051 SC CO 51ST INT TRANS)
PCat:	A41 USA FAM MBR AD	CS:		Outpt Rec. Rm:	
MC Status:		Status:		PCM:	ROBERTS,MICAH J
Insurance:	No			Tel. PCM:	

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STANDARD FORM 600 (REV. 5)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

Patient: **CHAJI, HOUDA**
Treatment Facility: **COMMUNITY MENTAL HEALTH SERVICE FT. IRWIN**
Patient Status: **Outpatient**

Date: **02 Mar 2011 0900 PDT**
Clinic: **PSYCHIATRY WACH**

Appt Type: **EST**
Provider: **JOHNSON,DAVID E**

Reason for Appointment: F/U
Appointment Comments:
scm2feb

A/P Written by JOHNSON,DAVID E @ 02 Mar 2011 0924 PDT
1. POST-TRAUMATIC STRESS DISORDER
Procedure(s): -Psychiat Therapy Indiv Appr 20-30 Min W/ Med Eval Managemt x 1

Disposition Written by JOHNSON,DAVID E @ 02 Mar 2011 0924 PDT
Released w/o Limitations

Note Written by JOHNSON,DAVID E @ 02 Mar 2011 0924 PDT
.

Weed MEDDAC Behavioral Health Department Followup

The patient's identity was verified via full name and date of birth.

ID
30 yo married female DEP with PTSD.
Subjective
Pt described events at the Article 32 hearing which made her upset. Another investigation needs to be completed before any decision is reached about further court proceedings. She was angry that the lawyer made the case about her, instead of the accused. She reported decent interactions with her husband, who is still deploying. She plans to let the children finish school year before she leaves here. She is taking the prazosin, and only rarely the doxepin. She takes the Prozac, though it still sounds like she takes it when she is upset.
MEDS
Prozac 40 mg daily
Prazosin 6 mg at bedtime
PAIN
No pain issues noted. Pain is 0 out of 10 today.
MSE
Appearance: appropriately dressed and groomed.
Movement: no psychomotor retardation or agitation
Eye Contact: fair;
Speech Rate/Volume: normal tone; normal rate.
Interaction with Examiner: interactive, smiling at times, non-tearful.
Mood: euthymic today
Affect: full range
Judgment: good
Insight: fair
Thought Processes: Linear, logical, goal-directed
Thought Content:
No AH/VH/delusions.

SI: no thoughts, plan, or intent
HI: none
ASSESSMENT
Continue supportive therapy and meds while legal situation continues to play out.

Name/SSN:	**CHAJI, HOUDA**	Sex:	F	Sponsor/SSN:	BELKHATIR, KHALID/
FMP/SSN:	.	Tel H:		Rank:	SPECIALIST
DOB:	**08 Apr 1980**	Tel W:		Unit:	WJTEAA (0051 SC CO 51ST INT TRANS)
PCat:	A41 USA FAM MBR AD	CS:		Outpt Rec. Rm:	
MC Status:		Status:		PCM:	ROBERTS,MICAH J
Insurance:	No			Tel. PCM:	

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Suicide risk was assessed as low.
Protective factors included no SI, no hopelessness, no h/o suicide attempts, husband's presence
Risk factors included anxiety and fear, marital tension

DIAGNOSIS

Axis I Posttraumatic stress disorder
Axis II deferred
Axis III none
Axis IV sexual assault
Axis V GAF 63

PLAN:

Prozac 40 mg daily.
Prazosin 6 mg at bedtime.
F/U with MAJ Eason for therapy

Patient was seen for 30 minutes.

Follow up in 4 weeks.

Med reconciliation completed. Pt given list of current meds.

Signed By JOHNSON, DAVID E (Psychiatrist, Schweinfurt Behavioral Health Clinic) @ 02 Mar 2011 0925

THIS INFORMATION IS PROTECTED BY THE PRIVACY ACT OF 1974 (PL-93-579). UNAUTHORIZED ACCESS TO THIS INFORMATION IS A VIOLATION OF FEDERAL LAW. VIOLATORS WILL BE PROSECUTED.

Patient: **CHAJI, HOUDA**
Treatment Facility: **WEED ACH**
Patient Status: **Outpatient**

Date: **24 Feb 2011 1000 PST**
Clinic: **SOCIAL WORK WACH**

Appt Type: **EST**
Provider: **EASON,DEBORAH L**

Reason for Appointment: f/u
Appointment Comments:
16feb aet

AutoCites Refreshed by EASON,DEBORAH @ 24 Feb 2011 1105 PST

Problems

Chronic:

- Visit for: screening for pulmonary tuberculosis
- Post-traumatic stress disorder
- Visit for: administrative purposes
- Visit for: screening exam
- Recent weight gain
- General counseling on contraception
- Cervical Pap smear
- Insomnia
- Gastroenteritis
- Xerosis cutis

Allergies

- No Known Allergies

SO Note Written by EASON,DEBORAH L @ 01 Mar 2011 1713 PST

Chief complaint

The Chief Complaint is: Depression and anxiety.

Reason for Visit

Visit for: 30 yo female family member presented to the Behavioral Health Clinic for follow up individual counseling session.
Referred by:

[X] Other: Sexual Assault Response Coordinator.

History of present illness

The Patient is a 30 year old female. Source of patient information was patient. Reliability of source of patient information was good.

No marital problems.

Personal history

Social history reviewed.
Personal history: Chronic emotional stress.
Behavioral history: No tobacco use.
Alcohol: No consumption of alcohol.
Home environment: Native language Arabic.
Financial status: Financial status is secure.
Marital: Currently married 10 years with daughter and son.
Functional status: Lack of social support from friends.

Subjective

Completed by patient:
Consent to Treatment: [X] YES
Limits of Confidentiality: [X] YES
Privacy Act: [X] YES.

Review of systems

Psychological symptoms: No racing thoughts.

Physical findings

Vital signs:

- Pain level (0-10) 0.

General appearance:

° Normal. ° Awake. ° Alert. ° Oriented to time, place, and person.

Neurological:

- Memory was impaired. ° Level of consciousness was normal. ° No decrease in concentrating ability was observed. ° Cognitive functioning was normal. ° No confusion was observed. ° No delirium was noted. ° No disorientation was observed.

Speech: ° Normal.

Name/SSN:	**CHAJI, HOUDA**	Sex:	F	Sponsor/SSN:	BELKHATIR, KHALID
FMP/SSN:		Tel H:		Rank:	SPECIALIST
DOB:	**08 Apr 1980**	Tel W:		Unit:	WJTEAA (0051 SC CO 51ST INT TRANS)
PCat:	A41 USA FAM MBR AD	CS:		Outpt Rec. Rm:	
MC Status:		Status:		PCM:	ROBERTS,MICAH J
Insurance:	No			Tel. PCM:	

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24 Feb 2011 1003

Facility: Weed ACH Fort Irwin, CA Clinic: Social Work Weed ACH Provider: EASON, DEBORAH L

Psychiatric Exam:

Appearance: ° Normal. ° Clothing was appropriate. ° Grooming was normal.
Demonstrated Behavior: ° No decreased eye-to-eye contact was observed.
Attitude: ° Showed no inability to engage. ° Not guarded. ° Cooperative. ° Not uncommunicative.
Mood: • Depressed. • Fearful. • Anxious.
Affect: • Tearful.
Thought Processes: • Racing thoughts were demonstrated. ° Not impaired.
Thought Content: ° Revealed no impairment. ° No obsessions. ° No paranoid ideations. ° No delusions. ° No suicidal tendency. ° No suicidal ideation. ° No suicidal plans. ° No suicidal intent. ° No homicidal tendencies. ° No homicidal ideations. ° No homicidal plans. ° No homicidal intent.

Spiritual assessment:

• Faith provides strength and comfort.

Objective

30 y/o female family member presented to the Behavioral Health Clinic for follow up counseling session. Patient currently in a depressed/unhappy mood, alert and oriented x3, groomed appropriately and dressed neatly in civilian clothing. Presently, patient reports anxiety and depression due to participation in legal proceedings concerning sexual assault. Patient was tearful throughout session due to court experience. Presently, family member is determined to proceed with court proceedings and is anxious to hear if the case will be going forward. Provider will continue to follow patient providing CBT and supportive counseling. Patient is scheduled to follow up with Behavioral Health on 2 March 2011 @ 1000.

A/P Last Updated by EASON,DEBORAH @ 01 Mar 2011 1619 PST

1. Post-traumatic stress disorder

Procedure(s): -Social Work Individual Outpatient Counseling 45-50 Minutes x 1

Disposition Last Updated by EASON,DEBORAH @ 01 Mar 2011 1626 PST

Released w/o Limitations

Follow up: with PCM and/or in the MENTAL HEALTH WACH clinic. - Comments: Currently, 30 yo female family member denies SI/HI and self-harm. Provider verbally contracted with patient to visit BH, report to the ED or contact 911 if she feels she will harm herself or others. Patient acknowledged agreement and understanding of the above contract for safety. Patient to follow up with Behavioral Health on 2 March 2011 @ 1100 for continued CBT and supportive counseling. Duration of session: 50 minutes.

Suicide Risk Assessment Scale (SAD PERSONS SCALE)

S - Sex: 0
A - Age: 0
D - Depression: X
P - Previous attempt: 0
E - Ethanol abuse: 0
R - Rational thinking loss: 0
S - Social Supports Lacking: 0
O - Organized Plan: 0
N - No Spouse: 0
S - Sickness: 0

Total: 1

The presence of each risk factor is assigned a point of 1. Higher scores indicate greater patient suicide risk.

0 -1 Minimal Risk
2-3 Low Risk
4-5 Moderate Risk
6-7 High Risk
8-11 Imminent Risk

Overall Risk of Self-Harm (or harm to others): MIN risk at this time.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Name/SSN: CHAJI, HOUDA	Sex: F	Sponsor/SSN: BELKHATIR, KHALID/
FMP/SSN:	Tel H:	Rank: SPECIALIST
DOB: 08 Apr 1980	Tel W:	Unit: WJTEAA (0051 SC CO 51ST INT TRANS)
PCat: A41 USA FAM MBR AD	CS:	Outpt Rec. Rm:
MC Status:	Status:	PCM: ROBERTS,MICAH J
Insurance: No		Tel. PCM:

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24 Feb 2011 1003
Facility: Weed ACH Fort Irwin, CA Clinic: Social Work Weed ACH Provider: EASON, DEBORAH L

Signed By EASON, DEBORAH (LCSW, BCD, Womack Army Medical Center, Department of Social Work) @ 01 Mar 2011 1717

Patient: **CHAJI, HOUDA**
Treatment Facility: **WEED ACH**
Patient Status: **Outpatient**

Date: **16 Feb 2011 0900 PST**
Clinic: **SOCIAL WORK WACH**

Appt Type: **EST**
Provider: **EASON,DEBORAH L**

Reason for Appointment: f/u
Appointment Comments:
15feb aet

AutoCites Refreshed by EASON,DEBORAH @ 16 Feb 2011 1004 PST

Problems

Chronic:

- Visit for: screening for pulmonary tuberculosis
- Post-traumatic stress disorder
- Visit for: administrative purposes
- Visit for: screening exam
- Recent weight gain
- General counseling on contraception
- Cervical Pap smear
- Insomnia
- Gastroenteritis
- Xerosis cutis

Allergies

- No Known Allergies

SO Note Written by EASON,DEBORAH L @ 22 Feb 2011 1554 PST

Chief complaint

The Chief Complaint is: Depression and anxiety.

Reason for Visit

Visit for: 30 yo female family member presented to the Behavioral Health Clinic for follow up individual counseling session.
Referred by:

[X] Other: Sexual Assault Response Coordinator.

History of present illness

The Patient is a 30 year old female. Source of patient information was patient. Reliability of source of patient information was good.

No marital problems.

Personal history

Social history reviewed.
Personal history: Chronic emotional stress.
Behavioral history: No tobacco use.
Alcohol: No consumption of alcohol.
Home environment: Native language Arabic.
Financial status: Financial status is secure.
Marital: Currently married 10 years with daughter and son.
Functional status: Lack of social support from friends.

Review of systems

Psychological symptoms: No racing thoughts.

Physical findings

Vital signs:

- Pain level (0-10) 0.

General appearance:

° Normal. ° Awake. ° Alert. ° Oriented to time, place, and person.

Neurological:

- Memory was impaired. ° Level of consciousness was normal. ° No decrease in concentrating ability was observed. ° Cognitive functioning was normal. ° No confusion was observed. ° No delirium was noted. ° No disorientation was observed.

Speech: ° Normal.

Psychiatric Exam:

Appearance: ° Normal. ° Clothing was appropriate. ° Grooming was normal.
Demonstrated Behavior: ° No decreased eye-to-eye contact was observed.
Attitude: ° Showed no inability to engage. ° Not guarded. ° Cooperative. ° Not uncommunicative.
Mood: ° Euthymic.

Name/SSN:	**CHAJI, HOUDA**	Sex: F		Sponsor/SSN:	BELKHATIR, KHALID
FMP/SSN:		Tel H:		Rank:	SPECIALIST
DOB:	**08 Apr 1980**	Tel W:		Unit:	WJTEAA (0051 SC CO 51ST INT TRANS)
PCat:	A41 USA FAM MBR AD	CS:		Outpt Rec. Rm:	
MC Status:		Status:		PCM:	ROBERTS,MICAH J
Insurance:	No			Tel. PCM:	

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Affect: ° Congruent with the mood.
Thought Processes: • Racing thoughts were demonstrated. ° Not impaired.
Thought Content: ° Revealed no impairment. ° No obsessions. ° No paranoid ideations. ° No delusions. ° No suicidal tendency. ° No suicidal ideation. ° No suicidal plans. ° No suicidal intent. ° No homicidal tendencies. ° No homicidal ideations. ° No homicidal plans. ° No homicidal intent.

Spiritual assessment:

• Faith provides strength and comfort.

Objective

30 y/o female family member presented to the Behavioral Health Clinic for follow up counseling session. Patient currently in a happy mood, alert and oriented x3, groomed appropriately and dressed neatly in civilian clothing. Presently, patient reports anxiety and depression due to occupational discord. Patient states fellow students who are aware of her sexual assault have "told everyone in the clinic (DENTAC) about what happened to me." Patient reports many of the women in the dental internship program are spouses of Soldiers in her husband's unit and "blame her for the sexual assault." Patient states she feels isolated at work and no one speaks to her apart from the receptionist. Patient voiced she is determined to complete her training and become a dental assistant. Additionally, patient reports her sexual assault trial has been rescheduled for 23 Feb 2011. Patient scheduled to follow up with behavioral health on 24 Feb 2011 @ 1000 for CBT and supportive counseling.

A/P Last Updated by EASON,DEBORAH @ 22 Feb 2011 0954 PST

1. POST-TRAUMATIC STRESS DISORDER

Procedure(s): -Social Work Individual Outpatient Counseling 45-50 Minutes x 1
-Psychiatric Evaluation Review of Records and Reports x 1

Disposition Last Updated by EASON,DEBORAH @ 22 Feb 2011 1056 PST

Released w/o Limitations

Follow up: with PCM and/or in the MENTAL HEALTH WACH clinic. - Comments: Currently, 30 yo female family member denies SI/HI and self-harm. Provider verbally contracted with patient to visit BH, report to the ED or contact 911 if she feels she will harm herself or others. Patient acknowledged agreement and understanding of the above contract for safety. Patient to follow up with Behavioral Health on 24 Feb 2011 @ 1000 for continued CBT and supportive counseling.

Suicide Risk Assessment Scale (SAD PERSONS SCALE)

S - Sex: 0
A - Age: 0
D - Depression: X
P - Previous attempt: 0
E - Ethanol abuse: 0
R - Rational thinking loss: 0
S - Social Supports Lacking: 0
O - Organized Plan: 0
N - No Spouse: 0
S - Sickness: 0

Total: 1

The presence of each risk factor is assigned a point of 1. Higher scores indicate greater patient suicide risk.

0 -1 Minimal Risk
2-3 Low Risk
4-5 Moderate Risk
6-7 High Risk
8-11 Imminent Risk

Overall Risk of Self-Harm (or harm to others): MIN risk at this time.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By EASON, DEBORAH (LCSW, BCD, Womack Army Medical Center, Department of Social Work) @ 22 Feb 2011 1559

Name/SSN:	**CHAJI, HOUDA**	Sex:	F	Sponsor/SSN:	BELKHATIR, KHALID/
FMP/SSN:		Tel H:		Rank:	SPECIALIST
DOB:	**08 Apr 1980**	Tel W:		Unit:	WJTEAA (0051 SC CO 51ST INT TRANS)
PCat:	A41 USA FAM MBR AD	CS:		Outpt Rec. Rm:	
MC Status:		Status:		PCM:	ROBERTS,MICAH J
Insurance:	No			Tel. PCM:	

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Patient: **CHAJI, HOUDA**
Treatment Facility: **COMMUNITY MENTAL HEALTH SERVICE FT. IRWIN**
Patient Status: **Outpatient**

Date: **02 Feb 2011 0900 PST**
Clinic: **PSYCHIATRY WACH**

Appt Type: **EST**
Provider: **JOHNSON,DAVID E**

Reason for Appointment: F/U
Appointment Comments:
scm7jan

A/P Written by JOHNSON,DAVID E @ 02 Feb 2011 0929 PST
1. POST-TRAUMATIC STRESS DISORDER
Procedure(s): -Psychiat Therapy Indiv Appr 20-30 Min W/ Med Eval Managemt x 1

Disposition Written by JOHNSON,DAVID E @ 02 Feb 2011 0929 PST
Released w/o Limitations

Note Written by JOHNSON,DAVID E @ 02 Feb 2011 0928 PST

Weed MEDDAC Behavioral Health Department Followup

The patient's identity was verified via full name and date of birth.

ID
30 yo married female DEP with PTSD.

Subjective
We discussed ongoing work at the dental clinic and recent frustration where she was told to follow the schedule, but the others did not do so. Rather than go back to her regular dentist she left work, went home, and shook and cried. The pt bought a sewing machine to keep her mind off the other matters. The article 32 was postponed again until late Feb. Her husband is now deploying for 1 year in April. The pt would like to return home in Georgia, though she is considering other options too. I recommended that family support would be a good thing for her at this point. She described fear of anyone sleeping at night – she will make her husband wake up if she is trying to sleep, for fear of an intruder coming in. She is not taking her Prozac daily, and it was not clear if she is taking the prazosin or not. She described ongoing dreams of being pursued or stalked.

MEDS
Prozac 40 mg daily
Prazosin 4 mg at bedtime

PAIN
No pain issues noted. Pain is 0 out of 10 today.

MSE
Appearance: appropriately dressed and groomed.
Movement: no psychomotor retardation or agitation
Eye Contact: fair;
Speech Rate/Volume: normal tone; normal rate.
Interaction with Examiner: interactive, smiling at times, non-tearful.
Mood: euthymic today
Affect: full range
Judgment: good
Insight: fair
Thought Processes: Linear, logical, goal-directed
Thought Content:
No AH/VH/delusions.

SI: no thoughts, plan, or intent

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HI: none

ASSESSMENT

The pt continues to pursue work and is now sewing as a hobby. I will try to get her to take prazosin 6 mg for nightmares. If she returns home in April she would be removed from the environment where she was attacked and from others who are accusing her of being a troublemaker. She would be able to fly here for any legal proceedings.

Suicide risk was assessed as low.
Protective factors included no SI, no hopelessness, no h/o suicide attempts, husband's presence
Risk factors included anxiety and fear, marital tension

DIAGNOSIS

Axis I Posttraumatic stress disorder
Axis II deferred
Axis III none
Axis IV sexual assault
Axis V GAF 63

PLAN:

Prozac 40 mg daily.
Prazosin 6 mg at bedtime.
F/U with MAJ Eason for therapy

Patient was seen for 30 minutes.

Follow up in 4 weeks.

Med reconciliation completed. Psychiatric meds reviewed with patient (or parents as applicable); patient instructed to obtain updated med list from pharmacy and to destroy any old lists.

Signed By JOHNSON, DAVID E (Psychiatrist, Schweinfurt Behavioral Health Clinic) @ 02 Feb 2011 0929

Patient: **CHAJI, HOUDA**
Treatment Facility: **WEED ACH**
Patient Status: **Outpatient**

Date: **25 Jan 2011 1500 PST**
Clinic: **SOCIAL WORK WACH**

Appt Type: **EST**
Provider: **EASON,DEBORAH L**

Reason for Appointment: F/U
Appointment Comments:
REN 19JAN11

AutoCites Refreshed by EASON,DEBORAH @ 25 Jan 2011 1614 PST

Problems

Chronic:
- Visit for: screening for pulmonary tuberculosis
- Post-traumatic stress disorder
- Visit for: administrative purposes
- Visit for: screening exam
- Recent weight gain
- General counseling on contraception
- Cervical Pap smear
- Insomnia
- Gastroenteritis
- Xerosis cutis

Allergies
- No Known Allergies

SO Note Written by EASON,DEBORAH L @ 27 Jan 2011 1754 PST

Chief complaint

The Chief Complaint is: Depression and anxiety.

Reason for Visit

Visit for: 30 yo female family member presented to the Behavioral Health Clinic for follow up individual counseling session.

History of present illness

The Patient is a 30 year old female.
She reported: Marital problems.

Personal history

Social history reviewed.
Personal history: Chronic emotional stress.
Behavioral history: No tobacco use.
Alcohol: No consumption of alcohol.
Home environment: Native language Arabic.
Financial status: Financial status is secure.
Marital: Currently married 10 years with daughter and son.
Functional status: Lack of social support from friends.

Review of systems

Psychological symptoms: No racing thoughts.

Physical findings

Vital signs:
- Pain level (0-10) 0.

General appearance:
° Normal. ° Awake. ° Alert. ° Oriented to time, place, and person.

Neurological:
- Memory was impaired. ° Level of consciousness was normal. ° No decrease in concentrating ability was observed. ° Cognitive functioning was normal. ° No confusion was observed. ° No delirium was noted. ° No disorientation was observed.

Speech: ° Normal.

Psychiatric Exam:
Appearance: ° Normal. ° Clothing was appropriate. ° Grooming was normal.
Demonstrated Behavior: ° No decreased eye-to-eye contact was observed.
Attitude: ° Showed no inability to engage. ° Not guarded. ° Cooperative. ° Not uncommunicative.
Mood: ° Euthymic.
Affect: ° Congruent with the mood.
Thought Processes: • Racing thoughts were demonstrated. ° Not impaired.
Thought Content: ° Revealed no impairment. ° No obsessions. ° No paranoid ideations. ° No delusions. ° No suicidal tendency. ° No suicidal ideation. ° No suicidal plans. ° No suicidal intent. ° No homicidal tendencies. ° No homicidal

Name/SSN:	**CHAJI, HOUDA**	Sex:	F	Sponsor/SSN:	BELKHATIR, KHALID
FMP/SSN:		Tel H:		Rank:	SPECIALIST
DOB:	**08 Apr 1980**	Tel W:		Unit:	WJTEAA (0051 SC CO 51ST INT TRANS)
PCat:	A41 USA FAM MBR AD	CS:		Outpt Rec. Rm:	
MC Status:		Status:		PCM:	ROBERTS,MICAH J
Insurance:	No			Tel. PCM:	

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ideations. ° No homicidal plans. ° No homicidal intent.

Spiritual assessment:

• Faith provides strength and comfort.

Objective

30 y/o female family member presented to the Behavioral Health Clinic for follow up counseling session. Patient currently alert and oriented x3, groomed appropriately and dressed neatly in civilian clothing. Presently, patient reports anxiety, insomnia and nightmares associated with her sexual assault. Patient states during the holiday season she remained in her house due to fear. Patient reports her spouse is currently away (until 27 Jan 2011) at WLC and she is anxious and afraid to be alone. Patient states she previously discontinued her medication (Prozac/Doxepin) because she wanted to be alert if her alleged attacker attempted to enter her home. Patient reports she has since resumed her medication which has helped her nightmares. Patient states the court date for the Article 32 is scheduled for 1 Feb 2011. Patient is anxious for the judicial procedure to be complete and is hopeful the alleged perpetrator will be incarcerated. Per patient, "I will have my honor back if he is placed in jail." Patient reports her marriage is improving and states her spouse sent her a letter from WLC reaffirming his love. Patient states she is currently focusing on the well-being of her family. Provider discussed with patient stress management techniques and the importance of taking her medication as prescribed. Patient is agreeable to continue to take medication regularly and to utilize stress management techniques when feeling anxious or stressed. Provider will continue to follow patient providing supportive counseling. Patient scheduled to follow up with behavioral health on 10 Feb 2011. Current treatment plan entails:

1. Increase patients understanding of depression/anxiety through patient education
2. Decrease symptoms of depression via CBT and supportive counseling
3. Improve mood, sleep and energy with relaxation techniques
4. Increase awareness of coping skills through patient education
5. Increase self confidence utilizing CBT~.

A/P Written by EASON,DEBORAH @ 27 Jan 2011 1739 PST

1. POST-TRAUMATIC STRESS DISORDER

Procedure(s): -Social Work Individual Outpatient Counseling 45-50 Minutes x 1
-Psychiatric Evaluation Review of Records and Reports x 1

Disposition Written by EASON,DEBORAH @ 27 Jan 2011 1751 PST

Released w/o Limitations

Follow up: as needed in the MENTAL HEALTH WACH clinic. - Comments: Currently, 30 yo female family member denies SI/HI and self-harm. Provider verbally contracted with patient to visit BH, report to the ED or contact 911 if she feels she will harm herself or others. Patient acknowledged agreement and understanding of the above contract for safety. Patient to continue to follow up with Behavioral Health for continued therapy.

Suicide Risk Assessment Scale (SAD PERSONS SCALE)

S - Sex: 0
A - Age: 0
D - Depression: X
P - Previous attempt: 0
E - Ethanol abuse: 0
R - Rational thinking loss: 0
S - Social Supports Lacking: 0
O - Organized Plan: 0
N - No Spouse: 0
S - Sickness: 0

Total: 1

The presence of each risk factor is assigned a point of 1. Higher scores indicate greater patient suicide risk.

0 -1 Minimal Risk
2-3 Low Risk
4-5 Moderate Risk
6-7 High Risk
8-11 Imminent Risk

Overall Risk of Self-Harm (or harm to others): MIN risk at this time.

25 Jan 2011 1445

Facility: Weed ACH Fort Irwin, CA **Clinic:** Social Work Weed ACH **Provider:** EASON, DEBORAH L

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By EASON, DEBORAH (LCSW, BCD, Womack Army Medical Center, Department of Social Work) @ 27 Jan 2011 1754

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Patient: **CHAJI, HOUDA**
Treatment Facility: **COMMUNITY MENTAL HEALTH SERVICE FT. IRWIN**
Patient Status: **Outpatient**

Date: **07 Jan 2011 0900 PST**
Clinic: **PSYCHIATRY WACH**

Appt Type: **EST**
Provider: **JOHNSON,DAVID E**

Reason for Appointment: f/u
Appointment Comments:
7dec aet

A/P Written by JOHNSON,DAVID E @ 07 Jan 2011 1504 PST
1. POST-TRAUMATIC STRESS DISORDER
Procedure(s): -Psychiat Therapy Indiv Appr 20-30 Min W/ Med Eval Managemt x 1

Disposition Written by JOHNSON,DAVID E @ 07 Jan 2011 1504 PST
Released w/o Limitations

Note Written by JOHNSON,DAVID E @ 07 Jan 2011 1503 PST
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Weed MEDDAC Behavioral Health Department Followup

The patient's identity was verified via full name and date of birth.

ID
30 yo married female DEP with PTSD.
Subjective
We discussed pt's ongoing fears about going outside, and for her children going to school. Her husband is at WLC, so she stopped her sleeping pills in order to be awake in case an intruder breaks in. She also stopped the Prozac, saying she wants to be better without medication. However, she reports 40 mg was doing better for her. The holidays were somewhat good, though not perfect. She discussed her husband giving her a letter affirming his commitment to her. She is focusing on the attacker going to jail at some point; the Article 32 will be 1 Feb. She feels she will be able to get better once he is in jail; I broached the topic that this is by no means a definite conclusion, and that she can get better even without such a definitive outcome.
MEDS
Prozac 40 mg daily
Doxepin 75-100 mg at bedtime PRN insomnia.
PAIN
No pain issues noted. Pain is 0 out of 10 today.
MSE
Appearance: appropriately dressed and groomed.
Movement: no psychomotor retardation or agitation
Eye Contact: fair;
Speech Rate/Volume: normal tone; normal rate.
Interaction with Examiner: interactive, smiling at times, non-tearful.
Mood: anxious and depressed
Affect: constricted
Judgment: good
Insight: fair
Thought Processes: Linear, logical, goal-directed
Thought Content:
No AH/VH/delusions.

SI: no thoughts, plan, or intent
HI: none

Name/SSN:	**CHAJI, HOUDA**	Sex:	F	Sponsor/SSN:	BELKHATIR, KHALID
FMP/SSN:		Tel H:		Rank:	SPECIALIST
DOB:	**08 Apr 1980**	Tel W:		Unit:	WJTEAA (0051 SC CO 51ST INT TRANS)
PCat:	A41 USA FAM MBR AD	CS:		Outpt Rec. Rm:	
MC Status:		Status:		PCM:	ROBERTS,MICAH J
Insurance:	No			Tel. PCM:	

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ASSESSMENT

Pt agrees to restart her meds. I will place her on prazosin instead of doxepin since she wants to not be sedated, but has been having nightmares about the attack.

Suicide risk was assessed as low.
Protective factors included no SI, no hopelessness, no h/o suicide attempts, husband's presence
Risk factors included anxiety and fear, marital tension

DIAGNOSIS

Axis I Posttraumatic stress disorder
Axis II deferred
Axis III none
Axis IV sexual assault
Axis V GAF 60

PLAN:

Prozac 40 mg daily.
Start prazosin 2 mg at bedtime.
Pt not currently using doxepin 75-100 mg at bedtime prn insomnia.

F/U with MAJ Eason for therapy

Patient was seen for 30 minutes.

Follow up in 4 weeks.

Med reconciliation completed. Psychiatric meds reviewed with patient (or parents as applicable); patient instructed to obtain updated med list from pharmacy and to destroy any old lists.

Signed By JOHNSON, DAVID E (Psychiatrist, Schweinfurt Behavioral Health Clinic) @ 07 Jan 2011 1504

Name/SSN:	CHAJI, HOUDA	Sex: F		Sponsor/SSN:	BELKHATIR, KHALID/
FMP/SSN:		Tel H:		Rank:	SPECIALIST
DOB:	08 Apr 1980	Tel W:		Unit:	WJTEAA (0051 SC CO 51ST INT TRANS)
PCat:	A41 USA FAM MBR AD	CS:		Outpt Rec. Rm:	
MC Status:		Status:		PCM:	ROBERTS,MICAH J
Insurance:	No			Tel. PCM:	

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Patient: **CHAJI, HOUDA**
Treatment Facility: **WEED ACH**
Patient Status: **Outpatient**

Date: **17 Dec 2010 0900 PST**
Clinic: **SOCIAL WORK WACH**

Appt Type: **EST**
Provider: **EASON,DEBORAH L**

Reason for Appointment: F/U
Appointment Comments:
REN 14DEC10

AutoCites Refreshed by EASON,DEBORAH @ 17 Dec 2010 1008 PST

Problems

Chronic:

- Visit for: screening for pulmonary tuberculosis
- Post-traumatic stress disorder
- Visit for: administrative purposes
- Visit for: screening exam
- Recent weight gain
- General counseling on contraception
- Cervical Pap smear
- Insomnia
- Gastroenteritis
- Xerosis cutis

Acute:

- Vaccine needed prophylactically against combinations of diseases

Allergies

- No Known Allergies

SO Note Written by EASON,DEBORAH L @ 21 Dec 2010 1428 PST

Chief complaint
The Chief Complaint is: Depression and anxiety.

Reason for Visit
Visit for: 30 yo female family member presented to the Behavioral Health Clinic for individual counseling following sexual assault. Referred by:

[X] Other: Sexual Assault Coordinator.

History of present illness
The Patient is a 30 year old female. Source of patient information was patient. Reliability of source of patient information was good.
Feeling overweight.
Anxiety. No depression.

Personal history
Social history reviewed.
Personal history: Chronic emotional stress.
Behavioral history: No tobacco use.
Alcohol: No consumption of alcohol.
Home environment: Difficulty reading English and the native language is Arabic.
Financial status: Financial status is secure.
Marital: Currently married 10 years with daughter and son.
Functional status: Lack of social support from friends.

Subjective
Completed by patient:
Consent to Treatment: [X] YES
Limits of Confidentiality: [X] YES
Privacy Act: [X] YES.

Review of systems
Psychological symptoms: No racing thoughts and no marital problems.

Physical findings
Vital signs:
- Pain level (0-10) 0.

General appearance:
° Normal. ° Awake. ° Alert. ° Oriented to time, place, and person.

Neurological:

Name/SSN:	**CHAJI, HOUDA**	Sex:	F	Sponsor/SSN:	BELKHATIR, KHALID/
FMP/SSN:		Tel H:		Rank:	SPECIALIST
DOB:	**08 Apr 1980**	Tel W:		Unit:	WJTEAA (0051 SC CO 51ST INT TRANS)
PCat:	A41 USA FAM MBR AD	CS:		Outpt Rec. Rm:	
MC Status:		Status:		PCM:	ROBERTS,MICAH J
Insurance:	No			Tel. PCM:	

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• Memory was impaired. ° Level of consciousness was normal. ° No decrease in concentrating ability was observed. ° Cognitive functioning was normal. ° No confusion was observed. ° No delirium was noted. ° No disorientation was observed.

Speech: ° Normal.

Psychiatric Exam:

Appearance: ° Normal. ° Clothing was appropriate. ° Grooming was normal.

Demonstrated Behavior: ° No decreased eye-to-eye contact was observed.

Attitude: ° Showed no inability to engage. ° Not guarded. ° Cooperative. ° Not uncommunicative.

Mood: ° Euthymic.

Affect: ° Congruent with the mood.

Thought Processes: • Racing thoughts were demonstrated. ° Not impaired.

Thought Content: ° Revealed no impairment. ° No obsessions. ° No paranoid ideations. ° No delusions. ° No suicidal tendency. ° No suicidal ideation. ° No suicidal plans. ° No suicidal intent. ° No homicidal tendencies. ° No homicidal ideations. ° No homicidal plans. ° No homicidal intent.

Spiritual assessment:

• Faith provides strength and comfort.

Objective

30 y/o family member presented to the Behavioral Health Clinic for follow up counseling session. Patient currently alert and oriented x3 groomed appropriately and dressed neatly in scrubs. This session patient reports anxiety associated with the sexual assault and problems at internship; however, denies marital discord and depression. Patient reports her alleged abuser presented to the Dental Clinic for an appt. this week. FM reports upon observing perpetrator she left the area and called her husband for advice. Ultimately, FM spoke with clinic NCO regarding restraining order. Patient reports NCO ordered her to the break room to avoid contact with the perpetrator. In addition, FM reports the same NCO recently called her into his office to discuss internship time sheets. NCO voiced it was brought to his attention that patient was falsifying internship hours. FM reports she was told she must sign in and out with the NCO to avoid any further problems with her internship hours. Patient reports she informed the NCO that she does not falsify her time and she requested to know who provided him with inaccurate information. Patient reports the NCO refused to inform her who accused her of misrepresenting her time. Patient feels the NCO is listening to the wives/friends of the Soldier's who work with her husband. Patient reports she refused to sign out with the NCO (due to inability to locate him when needed); however, she has agreed to have the physician sign her time sheet at the beginning and end of her shift. In addition to above, patient reports she received a disturbing call from one of her friends in Georgia. Patient states she was informed, by her friend, that someone with a Moroccan accent called her and reported FM was causing trouble at Fort Irwin, sleeping with Soldiers, etc. Additionally, patient reports family members back home (Morocco) have also been contacted and harassed. Patient believes the person contacting her friends/family is the spouse of the alleged perpetrator. Patient reports she is handling problems at work through supportive communication with spouse and with proper medication usage. Patient reports she has began to use her medication as prescribed. Patient states her anxiety is manageable and her marital relationship is improving. Presently, FM denies SI, HI or self-harm and is scheduled to follow up with this provider in January 2011 for continued counseling. Current treatment plan entails:

1. Increase patients understanding of depression/anxiety through patient education
2. Decrease symptoms of depression via CBT and supportive counseling
3. Improve mood, sleep and energy with relaxation techniques
4. Increase awareness of coping skills through patient education
5. Increase self confidence utilizing CBT.

A/P Last Updated by EASON,DEBORAH @ 20 Dec 2010 0955 PST

1. POST-TRAUMATIC STRESS DISORDER

Procedure(s): -Social Work Individual Outpatient Counseling 45-50 Minutes x 1

Disposition Written by EASON,DEBORAH @ 21 Dec 2010 1456 PST

Released w/o Limitations

Follow up: with PCM and/or in the MENTAL HEALTH WACH clinic. - Comments: Currently, 30 y/o female family member denies SI/HI and self-harm. Provider verbally contracted with patient to visit BH, report to the ED or contact 911 if she feels she will harm herself or others. Patient acknowledged agreement and understanding of the above contract for safety. Patient scheduled for follow up BH appt. 10 Jan 2011 @ 0900.

Suicide Risk Assessment Scale (SAD PERSONS SCALE)

S - Sex: 0
A - Age: 0
D - Depression: 0
P - Previous attempt: 0
E - Ethanol abuse: 0
R - Rational thinking loss: 0

Name/SSN:	CHAJI, HOUDA	Sex:	F	Sponsor/SSN:	BELKHATIR, KHALID/
FMP/SSN:		Tel H:		Rank:	SPECIALIST
DOB:	08 Apr 1980	Tel W:		Unit:	WJTEAA (0051 SC CO 51ST INT TRANS)
PCat:	A41 USA FAM MBR AD	CS:		Outpt Rec. Rm:	
MC Status:		Status:		PCM:	ROBERTS,MICAH J
Insurance:	No			Tel. PCM:	

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S - Social Supports Lacking: 0
O - Organized Plan: 0
N - No Spouse: 0
S - Sickness: 0

Total: 0

The presence of each risk factor is assigned a point of 1. Higher scores indicate greater patient suicide risk.

0 -1 Minimal Risk
2-3 Low Risk
4-5 Moderate Risk
6-7 High Risk
8-11 Imminent Risk

Overall Risk of Self-Harm (or harm to others): MIN risk at this time.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By EASON, DEBORAH (LCSW, BCD, Womack Army Medical Center, Department of Social Work) @ 21 Dec 2010 1457

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Patient: **CHAJI, HOUDA**
Treatment Facility: **WEED ACH**
Patient Status: **Outpatient**

Date: **07 Dec 2010 1100 PST**
Clinic: **SOCIAL WORK WACH**

Appt Type: **EST**
Provider: **EASON,DEBORAH L**

Reason for Appointment: f/u
Appointment Comments:
1dec aet

AutoCites Refreshed by EASON,DEBORAH @ 07 Dec 2010 1108 PST

Problems

Chronic:
- Visit for: screening for pulmonary tuberculosis
- Post-traumatic stress disorder
- Visit for: administrative purposes
- Visit for: screening exam
- Recent weight gain
- General counseling on contraception
- Cervical Pap smear
- Insomnia
- Gastroenteritis
- Xerosis cutis

Acute:
- Vaccine needed prophylactically against combinations of diseases

Allergies
- No Known Allergies

SO Note Written by EASON,DEBORAH L @ 10 Dec 2010 1615 PST

Chief complaint
The Chief Complaint is: Depression and anxiety.

Reason for Visit
Visit for: 30 yo female family member presented to the Behavioral Health Clinic for individual counseling following sexual assault. Referred by:

[X] Other: Sexual Assault Coordinator.

History of present illness
The Patient is a 30 year old female. Source of patient information was patient. Reliability of source of patient information was good.
Feeling overweight.
Feeling nervous, anxiety, and depression.

Personal history
Social history reviewed.
Personal history: Chronic emotional stress.
Behavioral history: No tobacco use.
Alcohol: No consumption of alcohol.
Home environment: Difficulty reading English and the native language is Arabic.
Financial status: Financial status is secure.
Marital: Currently married 10 years with daughter and son.
Functional status: Lack of social support from friends.

Subjective
Completed by patient:
Consent to Treatment: [X] YES
Limits of Confidentiality: [X] YES
Privacy Act: [X] YES.

Review of systems
Psychological symptoms: No racing thoughts.

Physical findings
Vital signs:
- Pain level (0-10) 0.

General appearance:
° Normal. ° Awake. ° Alert. ° Oriented to time, place, and person.

Neurological:

Name/SSN:	**CHAJI, HOUDA**	Sex: F		Sponsor/SSN:	BELKHATIR, KHALID/
FMP/SSN:		Tel H:		Rank:	SPECIALIST
DOB:	**08 Apr 1980**	Tel W:		Unit:	WJTEAA (0051 SC CO 51ST INT TRANS)
PCat:	A41 USA FAM MBR AD	CS:		Outpt Rec. Rm:	
MC Status:		Status:		PCM:	ROBERTS,MICAH J
Insurance:	No			Tel. PCM:	

CHRONOLOGICAL RECORD OF MEDICAL CARE

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STANDARD FORM 600 (REV. 5)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

• Memory was impaired. ° Level of consciousness was normal. ° No decrease in concentrating ability was observed. ° Cognitive functioning was normal. ° No confusion was observed. ° No delirium was noted. ° No disorientation was observed.

Speech: ° Normal.

Psychiatric Exam:

Appearance: ° Normal. ° Clothing was appropriate. ° Grooming was normal.
Demonstrated Behavior: ° No decreased eye-to-eye contact was observed.
Attitude: ° Showed no inability to engage. ° Not guarded. ° Cooperative. ° Not uncommunicative.
Mood: ° Euthymic.
Affect: ° Congruent with the mood.
Thought Processes: • Racing thoughts were demonstrated. ° Not impaired.
Thought Content: ° Revealed no impairment. ° No obsessions. ° No paranoid ideations. ° No delusions. ° No suicidal tendency. ° No suicidal ideation. ° No suicidal plans. ° No suicidal intent. ° No homicidal tendencies. ° No homicidal ideations. ° No homicidal plans. ° No homicidal intent.

Spiritual assessment:

• Faith provides strength and comfort.

Objective

30 y/o family member presented to the Behavioral Health Clinic for follow up counseling session. Patient currently in a depressed mood, alert and oriented x3, groomed appropriately and dressed neatly in scrubs. Patient reports she left dental clinic to attend BH session. Patient continues to reports feelings of anxiety, loneliness and marital discord due to alleged rape by service member. Patient states she is continuing to be harassed by spouses of Soldiers assigned to her husband's unit. Patient reports she was invited to a party by a staff member of the dental clinic. Patient states she initially refused the invitation; however, she reports the host continued to ask her to attend. Patient reports she discussed it with her husband who encouraged her to go to the party. Patient states when she arrived at the party it was going well and she felt happy to be among friends. However, patient reports the host husband joined the party and began to ask her questions regarding her husband's rank and unit. Patient reports she did not divulge the information which upset the host's spouse. Patient reports she became upset when another female spouse from her husband's unit discussed his name and rank. Patient reports an argument began and she was pushed, shoved and hit up against the wall by party members. Patient reports she broke free and contacted the MP's who drove her home. Patient states her spouse became upset when he was questioned by his command regarding the incident. Patient reports her husband stated, "If you don't stop making trouble I will divorce you and send you back home." Patient states she thought about leaving her husband; however, she reports "I love him too much." Patient reports the couple has been through too much together and she does not believe he would file for divorce. Provider spoke to patient regarding making sound decision in regard to friendship. Patient agreed it would be better to meet friends outside of her husband's unit. Patient continues to look for acceptance among the spouses of the Soldiers of her husband's unit. Provider processed the incident with the patient and provided educational cousneling regarding self-esteem and self-worth. Patient presently denies SI, HI or self-harm and is scheduled to follow up with this provider on 14 December 2010 @ 1500 for continued counseling. Current treatment plan entails:

1. Increase patients understanding of depression/anxiety through patient education
2. Decrease symptoms of depression via CBT and supportive counseling
3. Improve mood, sleep and energy with relaxation techniques
4. Increase awareness of coping skills through patient education
5. Increase self confidence utilizing CBT.

A/P Written by EASON,DEBORAH @ 10 Dec 2010 1614 PST

1. POST-TRAUMATIC STRESS DISORDER

Procedure(s): -Social Work Individual Outpatient Counseling 45-50 Minutes x 1
-Psychiatric Evaluation Review of Records and Reports x 1

Disposition Written by EASON,DEBORAH @ 10 Dec 2010 1615 PST

Released w/o Limitations

Follow up: with PCM and/or in the MENTAL HEALTH WACH clinic. - Comments: Currently, 30 yo female family member denies SI/HI and self-harm. Provider verbally contracted with patient to visit BH, report to the ED or contact 911 if she feels she will harm herself or others. Patient acknowledged agreement and understanding of the above contract for safety. Patient scheduled for follow up BH appt. on 14 December 2010 @ 1500.

Suicide Risk Assessment Scale (SAD PERSONS SCALE)

S - Sex: 0
A - Age: 0
D - Depression: 1
P - Previous attempt: 0
E - Ethanol abuse: 0
R - Rational thinking loss: 0

S - Social Supports Lacking: 0
O - Organized Plan: 0
N - No Spouse: 0
S - Sickness: 0

Total: 1

The presence of each risk factor is assigned a point of 1. Higher scores indicate greater patient suicide risk.

0-1 Minimal Risk
2-3 Low Risk
4-5 Moderate Risk
6-7 High Risk
8-11 Imminent Risk

Overall Risk of Self-Harm (or harm to others): MIN risk at this time.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By EASON, DEBORAH (LCSW, BCD, Womack Army Medical Center, Department of Social Work) @ 10 Dec 2010 1637

Patient: **CHAJI, HOUDA**
Treatment Facility: **COMMUNITY MENTAL HEALTH SERVICE FT. IRWIN**
Patient Status: **Outpatient**

Date: **07 Dec 2010 0900 PST**
Clinic: **PSYCHIATRY WACH**

Appt Type: **EST**
Provider: **JOHNSON,DAVID E**

Reason for Appointment: f/u
Appointment Comments:
18nov aet

A/P Written by JOHNSON,DAVID E @ 07 Dec 2010 1028 PST
1. POST-TRAUMATIC STRESS DISORDER
Procedure(s): -Psychiat Therapy Indiv Appr 20-30 Min W/ Med Eval Managemt x 1

Disposition Written by JOHNSON,DAVID E @ 07 Dec 2010 1028 PST
Released w/o Limitations

Note Written by JOHNSON,DAVID E @ 07 Dec 2010 1028 PST
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Weed MEDDAC Behavioral Health Department Followup

The patient's identity was verified via full name and date of birth.

ID
30 yo married female DEP with PTSD.

Subjective
Pt reported a recent incident at a party where she got into an argument with another spouse from her husband's unit. This eventually led to "six of them" pushing against a wall, cursing at her, and telling her to just leave. She called the MPs to take her home due to fear. She had previously told her husband to go to sleep since things were problem-free at that time. Later her husband was furious because his unit was asking him why did she call the MPs. The pt says her husband said he would send her away and divorce her if another "incident" occurred. She says he will not come in for marital sessions presently. Otherwise, she remains focused on her children and she enjoys her work. She is "lost" as far as deciding whether to stay here or not. The Article 32 was postponed indefinitely, but she feels forensic proof exists that corroborates her story. The pt reported running out of medications because she did not pick up the last scripts I put in for her. She started using an "old medication," apparently to sleep, and reports blurred vision in both eyes for 2 weeks since doing so. I gave her a specific list of medications to be thrown away so we know what she is taking exactly. She does not know any of the names of the meds still.

MEDS
Zoloft 100 mg daily
Doxepin 75-100 mg at bedtime PRN insomnia.
Medication history was reviewed.

PAIN
No pain issues noted. Pain is 0 out of 10 today.

MSE
Appearance: appropriately dressed and groomed.
Movement: no psychomotor retardation or agitation
Eye Contact: fair;
Speech Rate/Volume: normal tone; normal rate.
Interaction with Examiner: interactive, smiling at times, non-tearful.
Mood: anxious and depressed
Affect: constricted
Judgment: good
Insight: fair
Thought Processes: Linear, logical, goal-directed

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Thought Content:
No AH/VH/delusions.

SI: no thoughts, plan, or intent
HI: none

ASSESSMENT

Will switch from Zoloft to Prozac in search of a better response, though it's unclear what her compliance has been. Maintain on doxepin for now, and she is content seeing her new therapist.

Suicide risk was assessed as low.
Protective factors included no SI, no hopelessness, no h/o suicide attempts, husband's presence
Risk factors included anxiety and fear, marital tension

DIAGNOSIS

Axis I Posttraumatic stress disorder
Axis II deferred
Axis III none
Axis IV sexual assault
Axis V GAF 60

PLAN:
Stop Zoloft 100 mg daily.
Start Prozac 20 mg daily.
Maintain doxepin 75-100 mg at bedtime prn insomnia.

F/U with MAJ Eason for therapy

Patient was seen for 30 minutes.

Follow up in 4 weeks.

Med reconciliation completed. Psychiatric meds reviewed with patient (or parents as applicable); patient instructed to obtain updated med list from pharmacy and to destroy any old lists.

Signed By JOHNSON, DAVID E (Psychiatrist, Schweinfurt Behavioral Health Clinic) @ 07 Dec 2010 1028

Name/SSN: CHAJI, HOUDA	Sex: F	Sponsor/SSN: BELKHATIR, KHALID/
FMP/SSN:	Tel H:	Rank: SPECIALIST
DOB: 08 Apr 1980	Tel W:	Unit: WJTEAA (0051 SC CO 51ST INT TRANS)
PCat: A41 USA FAM MBR AD	CS:	Outpt Rec. Rm:
MC Status:	Status:	PCM: ROBERTS,MICAH J
Insurance: No		Tel. PCM:

CHRONOLOGICAL RECORD OF MEDICAL CARE

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