REQUEST FOR PRIVATE MEDICAL INFORMATION

For use of this form, see AR 40-66; the proponent agency is the OTSG

1. Date (YYYYMMDD): 20100928

2. Patient's Name and SSN.
SPC Gary Walter SALEH, 247-63-3730

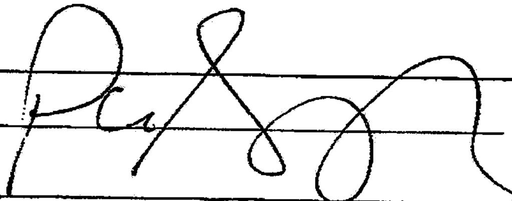
3. Medical Treatment Facility (Name and Location)
Weed Army Community Hospital,
Fort Irwin, CA 92310

4. Reason for Request.
Request the below listed documents or information in accordance with AR 40-66, Ch 2-4(1); AR 340-21, Ch 3-1 (a); and AR 195-2, Ch 3-15 (a&b) which are required for a matter currently under investigation by this office.
1. This request is made pursuant to HIPAA, paragraph 45 CFR, 164.512 (f)(1)(ii)(c), as an administrative request and authorized investigation demand authorized by law. I certify that:
A. The information sought is relevant and material to a legitimate law enforcement inquiry.
B. The request is specific and limited in scope to the extent reasonably practicable in light of the purpose for which is sought; and
C. There is no de-identified information that could reasonably be used due to the requirement for specific information on

5. Private Medical Information Sought (Specify dates of hospitalization or clinic visits and diagnosis, if known)

All behavioral and mental health records of SPC SALEH.

6. Requestor's Name, Title, Organization and SSN.
Special Agent Pierre D. TRAN:
Fort Irwin Resident Agency (CID)
Fort Irwin, CA 92310

Signature 

FOR USE OF MEDICAL TREATMENT FACILITY ONLY

7. Check applicable box.
[X] Approved [ ] Disapproved (State reason for disapproval)

8. Summary of Private Medical Information Released.
— All Mental health
Nothing Follows

9. Signature of Approving Official.

10. Date (YYYYMMDD): 20101115.

DA FORM 4254, FEB 2003 DA FORM 4254-R, NOV 91, IS OBSOLETE APD PE v1.02ES

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HEALTH RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

Patient: **SALEH, GARY WALTER**
Treatment Facility: **WEED ACH**
Patient Status: **Outpatient**

Date: **08 Nov 2010 1543 PST**
Clinic: **FAMILY ADVOCACY WACH**

Appt Type: **T-CON***
Provider: **GATES,WILLIAM**
Call Back Phone: **(808)-936-6997**

Reason for Telephone Consult: t-con

AutoCites Refreshed by GATES,WILLIAM P @ 08 Nov 2010 1606 PST

Problems

Chronic:

- Partial thickness (second degree) burns of two or more fingers, including thumb
- Acute reaction to stress with mixed disorders
- Testicular neoplasm
- Nicotine dependence
- Preventive medicine new patient evaluation adult 18-39
- Visit for: ears/hearing exam
- Need for typhoid vaccination
- Visit for: administrative purposes
- Visit for: military services physical
- Visit for: occupational health/fitness exam
- Nonvenomous insect bite

Family History

- No Family History of marital history (General FHx)
- No Family History of mental illness (not retardation) (General FHx)
- No Family History of alcoholism (General FHx)
- No family history [use for free text] (General FHx)

Allergies

- No Known Allergies

Active Medications

No Active Medications Found.

SO Note Written by GATES,WILLIAM @ 08 Nov 2010 1607 PST

Subjective

Phoned client to inform him that anger management group will not be held this Thursday, due to the holiday. Resume normal schedule 2 weeks.

A/P Last Updated by GATES,WILLIAM P @ 08 Nov 2010 1607 PST

1. PARTNER RELATIONAL PROBLEM

Disposition Last Updated by GATES,WILLIAM P @ 08 Nov 2010 1607 PST

Follow up: 2 week(s) or sooner if there are problems.

Signed By GATES, WILLIAM P (Physician/Workstation) @ 08 Nov 2010 1607

Name/SSN: SALEH, GARY WALTER/247633730

		Sex:	**M**	Sponsor/SSN:	SALEH, GARY WALTER/247633730
FMP/SSN:	**20/247633730**	Tel H:	808-936-6997	Rank:	SPECIALIST
DOB:	**08 Nov 1985**	Tel W:	808-285-9891	Unit:	WH53A0FC
PCat:	A11.2 USA ACTIVE DUTY ENLISTED	CS:		Outpt Rec. Rm:	SB TMC 1 RECORD ROOM
MC Status:		Status:		PCM:	SKEEN,PHILLIP MARK
Insurance:	No			Tel. PCM:	

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HEALTH RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

Patient: **SALEH, GARY WALTER**
Treatment Facility: **WEED ACH**
Patient Status: **Outpatient**

Date: **04 Nov 2010 1014 PST**
Clinic: **FAMILY ADVOCACY WACH**

Appt Type: **GRP**
Provider: **GATES,WILLIAM**

Reason for Appointment: grp

SO Note Written by GATES,WILLIAM @ 04 Nov 2010 1201 PST

Reason for Visit

Client presented for 90 min. anger management group therapy, facilitated by the Family Advocacy Program. He demonstrated active engagement in group, the theme of which was identifying common defense mechanisms utilized to cope with distressing situations, along with their various pros and cons. Used this general theme in an effort to facilitate greater self- and situational-insight in group members, who were asked to describe individual situations wherein they'd demonstrated a reaction with negative consequences, and how they could have acted differently.

Physical findings

General appearance:
° Normal.

Neurological:
° No hallucinations.
Speech: ° Normal. ° Sufficient nonverbal communication skills were demonstrated.

Psychiatric Exam:
Appearance: ° Normal.
Demonstrated Behavior: ° Behavior demonstrated no abnormalities.
Attitude: ° Not abnormal.
Mood: ° Euthymic.
Affect: ° Normal.
Thought Processes: ° Not impaired.
Thought Content: • Impaired insight (somewhat limited concerning emotional functioning). ° Revealed no impairment . ° No suicidal ideation. ° No suicidal plans. ° No suicidal intent. ° No homicidal ideations. ° No homicidal plans. ° No homicidal intent.

A/P Last Updated by GATES,WILLIAM P @ 04 Nov 2010 1202 PST

1. PARTNER RELATIONAL PROBLEM
Procedure(s): -Clinical Social Work Counseling Group x 1

Disposition Last Updated by GATES,WILLIAM P @ 04 Nov 2010 1202 PST

Released w/o Limitations
Follow up: 2 week(s) or sooner if there are problems.
Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By GATES, WILLIAM (Physician/Workstation) @ 04 Nov 2010 1203

Co-Signed By PETO, GENIEL A (FAP CASE MANAGER) @ 04 Nov 2010 1711

Name/SSN: SALEH, GARY WALTER/247633730

FMP/SSN: **20/247633730**
DOB: **08 Nov 1985**
PCat: A11.2 USA ACTIVE DUTY ENLISTED
MC Status:
Insurance: No

Sex: M
Tel H: 808-936-6997
Tel W: 808-285-9891
CS:
Status:

Sponsor/SSN: SALEH, GARY WALTER/247633730
Rank: SPECIALIST
Unit: WH53A0FC
Outpt Rec. Rm: SB TMC 1 RECORD ROOM
PCM: SKEEN,PHILLIP MARK
Tel. PCM:

CHRONOLOGICAL RECORD OF MEDICAL CARE
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HEALTH RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

Patient: **SALEH, GARY WALTER**
Treatment Facility: **WEED ACH**
Patient Status: **Outpatient**

Date: **28 Oct 2010 1347 PDT**
Clinic: **FAMILY ADVOCACY WACH**

Appt Type: **GRP**
Provider: **PETO,GENEIL A.**

Reason for Appointment: grp

AutoCites Refreshed by PETO,GENEIL A @ 28 Oct 2010 1641 PDT

Family History

- No Family History of marital history (General FHx)
- No Family History of mental illness (not retardation) (General FHx)
- No Family History of alcoholism (General FHx)
- No family history [use for free text] (General FHx)

Social History

No Social History Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
Trimethoprim 160mg + Sulfamethoxazole 800mg, (Septra DS), Tablet, Oral	Active	T1 TAB PO Q12H FOR 15 DAYS	NR	21 Oct 2010

SO Note Written by PETO,GENEIL A. @ 28 Oct 2010 1643 PDT

Subjective

S:Anger Mangement Group. Client adivsed he will not be present for next week's group.Client adivsed provately he is completing interactions iwth CID and is likely to be PCSing in the not too distant future. O: Cleint arrived a few minutes late. He was well groomed and was willing and able to engage in the group process. A: Group 3 new group members; we facilitated introductions. Group time was spent exploring how core beliefs drive an individual's thoughts and feelings which in turn drive actions and behaviors which in turn drive consequences. This knowledge assists clients with understanding the importance and value of altering thoughts and feelings, by utilizing critical thinking skills. We explored a number of situations to put the concept into practice and clients were encouraged to raise awareness in their individual interactions over the upcoming week. The majority of clients were actively engaged in this process, and reported benefiting from the discussion. HI/SI assesssment: Client's attitude and presentation do not raise HI/SI concerns. Client convincingly denies current HI/SI ideation.

A/P Written by PETO,GENEIL A @ 28 Oct 2010 1724 PDT

1. MARITAL PROBLEM

Procedure(s): -Clinical Social Work Counseling Group x 1

Disposition Written by PETO,GENEIL A @ 28 Oct 2010 1724 PDT

Released w/o Limitations

Follow up: as needed in 2 week(s) in the SOCIAL WORK WACH clinic or sooner if there are problems. - Comments: For AM grp

Signed By PETO, GENEIL A (FAP CASE MANAGER) @ 28 Oct 2010 1725

Name/SSN: SALEH, GARY WALTER/247633730

		Sex:	M	Sponsor/SSN:	SALEH, GARY WALTER/247633730
FMP/SSN:	20/247633730	Tel H:	808-936-6997	Rank:	SPECIALIST
DOB:	08 Nov 1985	Tel W:	808-285-9891	Unit:	WH53A0FC
PCat:	A11.2 USA ACTIVE DUTY ENLISTED	CS:		Outpt Rec. Rm:	SB TMC 1 RECORD ROOM
MC Status:		Status:		PCM:	SKEEN,PHILLIP MARK
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

HEALTH RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

Patient: **SALEH, GARY WALTER**
Treatment Facility: **COMMUNITY MENTAL HEALTH SERVICE FT. IRWIN**
Patient Status: **Outpatient**

Date: **21 Oct 2010 0848 PDT**
Clinic: **FAMILY ADVOCACY WACH**

Appt Type: **GRP**
Provider: **GATES,WILLIAM**

Reason for Appointment: Grp

SO Note Written by GATES,WILLIAM @ 21 Oct 2010 1432 PDT

Reason for Visit

FAP Anger Management Group: 90 min.

Subjective

Client demonstrated active engagement in group, the theme of which was the establishment of an internal locus of control through increased self-awareness. Client's presentation was calm and receptive. He demonstrated neither emotional distress nor disordered mentation. Using the CBT model as a discursive foundation, explored several tangible scenarios wherein an increase in cognitive awareness, and a decrease in auto-responsive behavior, would have resulted in better consequences. Client applied the concepts discussed to his personal situation. The group facilitators provided supportive feedback and encouragement, while challenging potentially dysfunctional interpretations of the discursive material. F/U for further anger management group counseling in 1 week.

Physical findings

General appearance:
° Normal.

Neurological:
° No hallucinations.
Speech: ° Normal. ° Sufficient nonverbal communication skills were demonstrated.

Psychiatric Exam:
Appearance: ° Normal.
Demonstrated Behavior: ° Behavior demonstrated no abnormalities.
Attitude: ° Not abnormal.
Mood: ° Euthymic.
Affect: ° Normal.
Thought Processes: ° Not impaired.
Thought Content: • Impaired insight (somewhat limited concerning emotional functioning). ° Revealed no impairment . ° No suicidal ideation. ° No suicidal plans. ° No suicidal intent. ° No homicidal ideations. ° No homicidal plans. ° No homicidal intent.

A/P Last Updated by GATES,WILLIAM P @ 21 Oct 2010 1428 PDT

1. Marital problem
Procedure(s): -Clinical Social Work Counseling Group x 1

Disposition Last Updated by GATES,WILLIAM P @ 21 Oct 2010 1432 PDT

Released w/o Limitations
Follow up: 1 week(s) or sooner if there are problems.
Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By GATES, WILLIAM (Physician/Workstation) @ 21 Oct 2010 1432

Co-Signed By PETO, GENIEL A (FAP CASE MANAGER) @ 21 Oct 2010 1515

CHANGE HISTORY

The following Disposition Note Was Overwritten by GATES,WILLIAM P @ 21 Oct 2010 1432 PDT:
Disposition section was last updated by GATES,WILLIAM P @ 21 Oct 2010 1432 PDT - see above.Previous Version of Disposition section was entered/updated by GATES,WILLIAM P @ 21 Oct 2010 1429 PDT.
Released w/o Limitations
Follow up: 1 week(s) or sooner if there are problems.
Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.
The following SO Note Was Overwritten by GATES,WILLIAM P @ 21 Oct 2010 1432 PDT:
SO Note Written by GATES,WILLIAM @ 21 Oct 2010 1427 PDT
Reason for Visit
FAP Anger Management Group: 90 min.
Subjective
Client demonstrated active engagement in group, the theme of which was the establishment of an internal locus of control through increased self-awareness. Client's presentations was calm and receptive. He demonstrated neither emotional distress nor disordered mentation. Using the CBT model as a discursive foundation, explored several tangible scenarios wherein an increase in cognitive awareness, and a decrease in auto-responsive behavior, would have resulted in better consequences. Client

Name/SSN: SALEH, GARY WALTER/247633730

		Sex:	M	Sponsor/SSN:	SALEH, GARY WALTER/247633730
FMP/SSN:	**20/247633730**	Tel H:	808-936-6997	Rank:	SPECIALIST
DOB:	**08 Nov 1985**	Tel W:	808-285-9891	Unit:	WH53A0FC
PCat:	A11.2 USA ACTIVE DUTY ENLISTED	CS:		Outpt Rec. Rm:	SB TMC 1 RECORD ROOM
MC Status:		Status:		PCM:	SKEEN,PHILLIP MARK
Insurance:	No			Tel. PCM:	

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

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE

21 Oct 2010 0849
Facility: Weed ACH Fort Irwin, CA **Clinic: FAMILY ADVOCACY WACH** **Provider: GATES,WILLIAM**

applied the concepts discussed to his personal situation. The group facilitators provided supportive feedback and encouragement, while challenging potentially dysfunctional interpretations of the discursive material. F/U for further anger management group counseling in 1 week.

Physical findings

General appearance:
- Normal.

Neurological:
- No hallucinations.
- Speech: ° Normal. ° Sufficient nonverbal communication skills were demonstrated.

Psychiatric Exam:
- Appearance: ° Normal.
- Demonstrated Behavior: ° Behavior demonstrated no abnormalities.
- Attitude: ° Not abnormal.
- Mood: ° Euthymic.
- Affect: ° Normal.
- Thought Processes: ° Not impaired.
- Thought Content: • Impaired insight (somewhat limited concerning emotional functioning). ° Revealed no impairment . ° No suicidal ideation. ° No suicidal plans. ° No suicidal intent. ° No homicidal ideations. ° No homicidal plans. ° No homicidal intent.

The following Signature(s) No Longer Applies because this Encounter Was Opened for Amendment by GATES,WILLIAM P @ 21 Oct 2010 1432 PDT:

Signed GATES, WILLIAM (Physician/Workstation) @ 21 Oct 2010 1429

Name/SSN: SALEH, GARY WALTER/247633730

		Sex:	M	Sponsor/SSN:	SALEH, GARY WALTER/247633730
FMP/SSN:	**20/247633730**	Tel H:	808-936-6997	Rank:	SPECIALIST
DOB:	**08 Nov 1985**	Tel W:	808-285-9891	Unit:	WH53A0FC
PCat:	A11.2 USA ACTIVE DUTY ENLISTED	CS:		Outpt Rec. Rm:	SB TMC 1 RECORD ROOM
MC Status:		Status:		PCM:	SKEEN,PHILLIP MARK
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

HEALTH RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

Patient: **SALEH, GARY WALTER**
Treatment Facility: **COMMUNITY MENTAL HEALTH SERVICE FT. IRWIN**
Patient Status: **Outpatient**

Date: **14 Oct 2010 1536 PDT**
Clinic: **FAMILY ADVOCACY WACH**

Appt Type: **GRP**
Provider: **PETO,GENEIL A.**

Reason for Appointment: grp

AutoCites Refreshed by PETO,GENIEL A @ 19 Oct 2010 1742 PDT

Family History
- No Family History of marital history (General FHx)
- No Family History of mental illness (not retardation) (General FHx)
- No Family History of alcoholism (General FHx)
- No family history [use for free text] (General FHx)

Social History

No Social History Found.

Active Medications
No Active Medications Found.

SO Note Written by PETO,GENEIL A. @ 19 Oct 2010 1742 PDT
History of present illness

The Patient is a 24 year old male.
He reported: Encounter Background Information: Anger management Group
S:Client reports utilizing the information obtained in this class is assisting him in understanding more, "Why I do what I do".
O:Client arrived on time, appropriately dressed; he was alert and engaged in the group, giving support and feedback to peers
A: Group discussion focused on personal accountability; specifically planned responsees versus auto responses with the goal of changing dynamics based on critical thinking. Gary pushed a lcient to disclsose in more depth and with more truth the reality of his incident; this was a powerful opportunity for this client to demonstrate personal accountablity, and indicates clients willingness to be accoutnable for his own actions and behaviors.
P:Clients continue to be encouraged to explore alternatives to auto responses, and to be more congnizant of the nature of outcomes when doing so.

A/P Written by PETO,GENIEL A @ 19 Oct 2010 1746 PDT
1. MARITAL PROBLEM
Procedure(s): -Clinical Social Work Counseling Group x 1

Disposition Written by PETO,GENIEL A @ 19 Oct 2010 1746 PDT
Released w/o Limitations
Follow up: 1 week(s) with PCM and/or in the SOCIAL WORK WACH clinic or sooner if there are problems.
Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By PETO, GENIEL A (FAP CASE MANAGER) @ 19 Oct 2010 1746

Name/SSN: SALEH, GARY WALTER/247633730

		Sex:	M	Sponsor/SSN:	SALEH, GARY WALTER/247633730
FMP/SSN:	20/247633730	Tel H:	808-936-6997	Rank:	SPECIALIST
DOB:	08 Nov 1985	Tel W:	808-285-9891	Unit:	WH53A0FC
PCat:	A11.2 USA ACTIVE DUTY ENLISTED	CS:		Outpt Rec. Rm:	SB TMC 1 RECORD ROOM
MC Status:		Status:		PCM:	SKEEN,PHILLIP MARK
Insurance:	No			Tel. PCM:	

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HEALTH RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

Patient: **SALEH, GARY WALTER**
Treatment Facility: **COMMUNITY MENTAL HEALTH SERVICE FT. IRWIN**
Patient Status: **Outpatient**

Date: **13 Oct 2010 1100 PDT**
Clinic: **FAMILY ADVOCACY WACH**

Appt Type: **EST**
Provider: **PETO,GENEIL A.**

Reason for Appointment: f/u
Appointment Comments:
mfh100410

AutoCites Refreshed by PETO,GENIEL A @ 19 Oct 2010 0722 PDT

Family History

- No Family History of marital history (General FHx)
- No Family History of mental illness (not retardation) (General FHx)
- No Family History of alcoholism (General FHx)
- No family history [use for free text] (General FHx)

Social History

No Social History Found.

Active Medications
No Active Medications Found.

SO Note Written by PETO,GENEIL A. @ 19 Oct 2010 0723 PDT
History of present illness

The Patient is a 24 year old male.

He reported: Encounter Background Information: Post CRC initial individual therapy S: Client reported increased awareness regarding insecurities that keep him in survival mode, information he has gleamed via anger managment group.

O: Client arrived on time, willing and able to engage with me. Client presented as friendly and cooperative and invested in facilitating enduring change. His speech was clear, he was alert iwth normal movement. His affect was unremarkable and appropirate to circumstances. Client's memory appeared intact and he was oriented X4. No gross abnormalities regarding thought process/content was noted; he was devoid of obvious perceptual disturbances and demonstrated fair reasoning, judgment and insight.

A: Client continues to demonstrate a deisre to facilitate enduring change, by increased awareness regarding his auto responses. Cleint discussed an issue involving an helicopter he wanted to give to a 3 year old child, which was an issue for his wife. Via discussion client was able to identify the superficial aspect he and his wife were focsuing on was quite different from the underlying reality, and the benefits of recogninzing this in an effort to more effectively communicate the deeper meaining of actions and behaviors. Client indicated an understanding of the issues discussed and reports a willingness to continue to work toward increased communication abilitiy in his relationship. Client will continue to work on being more cognizant of "little Gary"' s needs, in order to be more accountable in his interactions.

P:Client and I will continue to work on self-efficacy and communication skills. HI/SI assessment: Chronic risk-factor(s) - Perpetuating Risk Factors - permanent and non-modifiable:Male, anticipating separation/divorce; Parental History of substance abuse; History of impulsive/reckless bahaviors, History of Violent behaviors. Predisposing and Potentially Modifiable Risk Factors: Axis II characteristics; low self-esteem

Acute risk-factor(s): Relationship stressors; Anticipating separation/divorce; denied current suicidal ideation but endorses past suicidal ideation with no plan, and indicates that he would be more lieklty to exhibit depresssive symptomology such as isolation than attempt suicide currently; Psychological Pain in response to the loss of relationship which he endorses as the only thing thing that keeps him going; Unresolved anger; Poor Problem-solving skills; Cognitive Constriction, Few reasons for living/Loss of meaning

Mitigating factor(s):denied suicidal ideation, no recent history of suicide attempts, no previous history of suicide attempts, absence of alcohol/substance abuse, absence of psychosis, no weapon in the home, willingness to engage in counseling.

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

A/P Written by PETO,GENIEL A @ 19 Oct 2010 0731 PDT

Name/SSN: SALEH, GARY WALTER/247633730

		Sex:	M	Sponsor/SSN:	SALEH, GARY WALTER/247633730
FMP/SSN:	**20/247633730**	Tel H:	808-936-6997	Rank:	SPECIALIST
DOB:	**08 Nov 1985**	Tel W:	808-285-9891	Unit:	WH53A0FC
PCat:	A11.2 USA ACTIVE DUTY ENLISTED	CS:		Outpt Rec. Rm:	SB TMC 1 RECORD ROOM
MC Status:		Status:		PCM:	SKEEN,PHILLIP MARK
Insurance:	No			Tel. PCM:	

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HEALTH RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

19 Oct 2010 0722
Facility: Weed ACH Fort Irwin, CA **Clinic: FAMILY ADVOCACY WACH** **Provider: PETO,GENEIL A.**

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

Disposition Written by PETO,GENIEL A @ 19 Oct 2010 0731 PDT
Released w/o Limitations
Follow up: as needed in 1 week(s) in the FAMILY ADVOCACY WACH clinic or sooner if there are problems.
Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By PETO, GENIEL A (FAP CASE MANAGER) @ 19 Oct 2010 0731

Name/SSN: SALEH, GARY WALTER/247633730

		Sex:	M	Sponsor/SSN:	SALEH, GARY WALTER/247633730
FMP/SSN:	**20/247633730**	Tel H:	808-936-6997	Rank:	SPECIALIST
DOB:	**08 Nov 1985**	Tel W:	808-285-9891	Unit:	WH53A0FC
PCat:	A11.2 USA ACTIVE DUTY ENLISTED	CS:		Outpt Rec. Rm:	SB TMC 1 RECORD ROOM
MC Status:		Status:		PCM:	SKEEN,PHILLIP MARK
Insurance:	No			Tel. PCM:	

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HEALTH RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

Patient: **SALEH, GARY WALTER**
Treatment Facility: **WEED ACH**
Patient Status: **Outpatient**

Date: **08 Oct 2010 1330 PDT**
Clinic: **FAMILY ADVOCACY WACH**

Appt Type: **EST**
Provider: **PETO,GENEIL A.**

Reason for Appointment: F/U
Appointment Comments:
mfh100410

AutoCites Refreshed by PETO,GENIEL A @ 12 Oct 2010 1641 PDT

Family History

- No Family History of marital history (General FHx)
- No Family History of mental illness (not retardation) (General FHx)
- No Family History of alcoholism (General FHx)
- No family history [use for free text] (General FHx)

Social History

No Social History Found.

Active Medications
No Active Medications Found.

SO Note Written by PETO,GENEIL A. @ 12 Oct 2010 1656 PDT
History of present illness

The Patient is a 24 year old male.

He reported: Encounter Background Information: Post CRC initial individual therapy S: Client reported, "I am a different person at home than I am at work...I want to be the same.".

O: Client arrived on time, willing and able to engage with me. Client presented as friendly and cooperative and invested in facilitating enduring chagne. His speech was clear, he was alert iwth normal movement. His affect was unremarkable and appropirate to circumstances. Client's memory appeared intact and he was oriented X4. No gross abnormalities regarding thought process/content was noted; he was devoid of obvious perceptual disturbances and demonstrated fair reasoning, judgment and insight.

A: Client and I utilized this session to explore the incongruent selves he portrays at home and work in order to assist client in acknowledging the change he would like to facilitate. Client examined his upbringing and how he was resentful of being identified as good or bad based on his performance on job duties in the home, never based on his own merit, which keeps him past directed. THis led to the development of coping mechanisms of telling people what they want to hear, to avoid the immediate wrath,lending credence to the intention of surviving the moment at what ever the cost. This has left the client with limited internal locus of control. We will be working on enhancing client's ability to be accountable, without being in survival mode, by developing an external locus of control, via the use of CBT and inner-child work. Over the course of the next week client will be working on making his environment safe for "little Gary". We role-played how to facilitate this..."I've got this little guy, you go outside and play and I will manage this, you can leave it with me", the message he never got growing up. Client indicated this would be effective work in helping him be less reactive and more in control of his auto responses.

P:Client and I will work on enhancing self-efficacy. HI/SI assessment: Chronic risk-factor(s) - Perpetuating Risk Factors - permanent and non-modifiable:Male, anticipating separation/divorce; Parental History of substance abuse; History of impulsive/reckless bahaviors, History of Violent behaviors. Predisposing and Potentially Modifiable Risk Factors: Axis II characteristics; low self-esteem

Acute risk-factor(s): Relationship stressors; Anticipating separation/divorce; denied current suicidal ideation but endorses past suicidal ideation with no plan, and indicates that he would be more lieklty to exhibit depresssive symptomology such as isolation than attempt suicide currently; Psychological Pain in response to the loss of relationship which he endorses as the only thing thing that keeps him going; Unresolved anger; Poor Problem-solving skills; Cognitive Constriction, Few reasons for living/Loss of meaning

Mitigating factor(s):denied suicidal ideation, no recent history of suicide attempts, no previous history of suicide attempts, absence of alcohol/substance abuse, absence of psychosis, no weapon in the home, willingness to engage in counseling.

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

Name/SSN: SALEH, GARY WALTER/247633730

		Sex:	M	Sponsor/SSN:	SALEH, GARY WALTER/247633730
FMP/SSN:	**20/247633730**	Tel H:	808-936-6997	Rank:	SPECIALIST
DOB:	**08 Nov 1985**	Tel W:	808-285-9891	Unit:	WH53A0FC
PCat:	A11.2 USA ACTIVE DUTY ENLISTED	CS:		Outpt Rec. Rm:	SB TMC 1 RECORD ROOM
MC Status:		Status:		PCM:	SKEEN,PHILLIP MARK
Insurance:	No			Tel. PCM:	

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HEALTH RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

08 Oct 2010 1346
Facility: Weed ACH Fort Irwin, CA **Clinic: FAMILY ADVOCACY WACH** **Provider: PETO,GENEIL A.**

A/P Last Updated by PETO,GENIEL A @ 12 Oct 2010 1652 PDT
1. Marital problem
Procedure(s): -Social Work Individual Outpatient Counseling 45-50 Minutes x 1

Disposition Last Updated by PETO,GENIEL A @ 12 Oct 2010 1653 PDT
Released w/o Limitations
Follow up: 1 week(s) with PCM and/or in the FAMILY ADVOCACY WACH clinic or sooner if there are problems.
Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By PETO, GENIEL A (FAP CASE MANAGER) @ 12 Oct 2010 1657

CHANGE HISTORY
The following SO Note Was Overwritten by PETO,GENIEL A @ 12 Oct 2010 1656 PDT:
SO Note Written by PETO,GENEIL A. @ 12 Oct 2010 1641 PDT
History of present illness

The Patient is a 24 year old male.

He reported: Encounter Background Information: Post CRC initial individual therapy S: Client reported, "I am a different person at home than I am at work...I want to be the same.".

O: Client arrived on time, willing and able to engage with me. Client presented as friendly and cooperative and invested in facilitating enduring chagne. His speech was clear, he was alert iwth normal movement. His affect was unremarkable and appropirate to circumstances. Client's memory appeared intact and he was oriented X4. No gross abnormalities regarding thought process/content was noted; he was devoid of obvious perceptual disturbances and demonstrated fair reasoning, judgment and insight. A: Client and I utilized this session to explore the incongruent selves he portrays at home and work in order to assist client in acknowledging the change he would like to facilitate. Client examined his upbringing and how he was resentful of being identified as good or bad based on his performance on job duties in the home, never based on his own merit, which keeps him past directed. THis led to the development of coping mechanisms of telling people what they want to hear, to avoid the immediate wrath,lending credence to the intention of surviving the moment at what ever the cost. This has left the client with limited internal locus of control. We will be working on enhancing client's ability to be accountable, without being in survival mode, by developing an external locus of control, via the use of CBT and inner-child work. Over the course of the next week client will be working on making his environment safe for "little Gary". We role-played how to facilitate this..."I've got this little guy, you go outside and play and I will manage this, you can leave it with me", the message he never got growing up. Client indicated this would be effective work in helping him be less reactive and more in control of his auto responses. P:Client and I will work on enhancing self-efficacy. HI/SI assessment;

Name/SSN: SALEH, GARY WALTER/247633730

		Sex:	M	Sponsor/SSN:	SALEH, GARY WALTER/247633730
FMP/SSN:	**20/247633730**	Tel H:	808-936-6997	Rank:	SPECIALIST
DOB:	**08 Nov 1985**	Tel W:	808-285-9891	Unit:	WH53A0FC
PCat:	A11.2 USA ACTIVE DUTY ENLISTED	CS:		Outpt Rec. Rm:	SB TMC 1 RECORD ROOM
MC Status:		Status:		PCM:	SKEEN,PHILLIP MARK
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

HEALTH RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

Patient: **SALEH, GARY WALTER**
Treatment Facility: **WEED ACH**
Patient Status: **Outpatient**

Date: **07 Oct 2010 1012 PDT**
Clinic: **FAMILY ADVOCACY WACH**

Appt Type: **GRP**
Provider: **PETO,GENEIL A.**

Reason for Appointment: GRP

AutoCites Refreshed by PETO,GENIEL A @ 07 Oct 2010 1549 PDT

Family History
- No Family History of marital history (General FHx)
- No Family History of mental illness (not retardation) (General FHx)
- No Family History of alcoholism (General FHx)
- No family history [use for free text] (General FHx)

Social History

No Social History Found.

Active Medications
No Active Medications Found.

SO Note Written by PETO,GENEIL A. @ 07 Oct 2010 1633 PDT
History of present illness
The Patient is a 24 year old male.
He reported: Encounter Background Information: Group Anger Management as recommeneded by CRC. S:Client introduced himself to the group. O: Client arrived on time, willing and able to engage with the group. A: Group discussion focused on reviewing the information we have been learning from a critial thinking/communication perspective. Clients actively engaged in the process utilizing the common language that has been developed. One group member discussed insights he has developed over the past two weeks of group attendance, reporting to the group how changing his perspective has improved his communication at home. We disucssed the possiblity identified changes could be part of the DV cycle, to garner increased awareness via critical thinking skills. Another client reviewed his incident of record, and was able to appreciate the superficial nature of his thought process. P:Clients have been encouraged to utilize information from group in interactions across the span of the next week; clients will atttend group next week. Client relates his benefit from group a 7 on a scale of 1-10. HI/SI assessment; Client denies current HI/SI, and his participation in group indicates he is future oriented.

A/P Written by PETO,GENIEL A @ 07 Oct 2010 1634 PDT
1. MARITAL PROBLEM
Procedure(s): -Clinical Social Work Counseling Group x 1

Disposition Written by PETO,GENIEL A @ 07 Oct 2010 1636 PDT
Released w/o Limitations
Follow up: as needed in 1 week(s) in the SOCIAL WORK WACH clinic or sooner if there are problems. - Comments: For AM grp
Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By PETO, GENIEL A (FAP CASE MANAGER) @ 07 Oct 2010 1636

Name/SSN: SALEH, GARY WALTER/247633730

		Sex:	M	Sponsor/SSN:	SALEH, GARY WALTER/247633730
FMP/SSN:	**20/247633730**	Tel H:	808-936-6997	Rank:	SPECIALIST
DOB:	**08 Nov 1985**	Tel W:	808-285-9891	Unit:	WH53A0FC
PCat:	A11.2 USA ACTIVE DUTY ENLISTED	CS:		Outpt Rec. Rm:	SB TMC 1 RECORD ROOM
MC Status:		Status:		PCM:	SKEEN,PHILLIP MARK
Insurance:	No			Tel. PCM:	

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HEALTH RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

Patient: **SALEH, GARY WALTER**
Treatment Facility: **WEED ACH**
Patient Status: **Outpatient**

Date: **04 Oct 2010 0922 PDT**
Clinic: **FAMILY ADVOCACY WACH**

Appt Type: **EST**
Provider: **PETO,GENEIL A.**

Reason for Appointment: Case management post CRC

AutoCites Refreshed by PETO,GENIEL A @ 04 Oct 2010 0923 PDT

Family History

- No Family History of marital history (General FHx)
- No Family History of mental illness (not retardation) (General FHx)
- No Family History of alcoholism (General FHx)
- No family history [use for free text] (General FHx)

Social History

No Social History Found.

Active Medications
No Active Medications Found.

SO Note Written by PETO,GENEIL A. @ 04 Oct 2010 0928 PDT
History of present illness

The Patient is a 24 year old male.

He reported: Encounter Background Information: Post CRC initial case management. S: Client reported, "Crazy things going on, have stopped us from PCSing as planned, but they are working on it, and it shouldn't be too much longer". O: Client arrived without an appointment as a result of his Command advising him to do so. A: We reviewed the CRC findings, "met criteria" for physical and emotional abuse. Cleint was advised treatment recommendations include Individual, marital, anger management and case management. Client indicated a willingness to participate in all modalities; we disucssed specifically the fact marital will be at some point in the future. Client will begin attending Anger Management 10/7 at 8:30. Client has also scheduled individual therapy for 10/8 at 13:30 and case mgmt for 10/13 at 11:00 for 30 minutes.P:Client and I will work on enhancing self-efficacy. HI/SI assessment; Client reports he is doing well despite the stress he is under with CID investigation. He denies current suicidal ideation.

Military service.

A/P Written by PETO,GENIEL A @ 04 Oct 2010 0927 PDT
1. MARITAL PROBLEM
Procedure(s): -Social Work Individual Outpatient Counseling 20-30 Minutes x 1 (52-REDUCED SERVICES)

Disposition Written by PETO,GENIEL A @ 04 Oct 2010 0937 PDT
Released w/o Limitations
Follow up: as needed in 4 day(s) or sooner if there are problems.
Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By PETO, GENIEL A (FAP CASE MANAGER) @ 04 Oct 2010 0937

Name/SSN: SALEH, GARY WALTER/247633730

		Sex:	M	Sponsor/SSN:	SALEH, GARY WALTER/247633730
FMP/SSN:	20/247633730	Tel H:	808-936-6997	Rank:	SPECIALIST
DOB:	08 Nov 1985	Tel W:	808-285-9891	Unit:	WH53A0FC
PCat:	A11.2 USA ACTIVE DUTY ENLISTED	CS:		Outpt Rec. Rm:	SB TMC 1 RECORD ROOM
MC Status:		Status:		PCM:	SKEEN,PHILLIP MARK
Insurance:	No			Tel. PCM:	

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HEALTH RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

Patient: **SALEH, GARY WALTER**
Treatment Facility: **WEED ACH**
Patient Status: **Outpatient**

Date: **19 Aug 2010 1122 PDT**
Clinic: **FAMILY ADVOCACY WACH**

Appt Type: **T-CON***
Provider: **PETO,GENEIL A.**
Call Back Phone: **(808)-936-6997**

Reason for Telephone Consult: F/U with Command post assessement (as per Command request)

AutoCites Refreshed by PETO,GENIEL A @ 19 Aug 2010 1123 PDT

Family History

- No Family History of marital history (General FHx)
- No Family History of mental illness (not retardation) (General FHx)
- No Family History of alcoholism (General FHx)
- No family history [use for free text] (General FHx)

Social History

No Social History Found.

Active Medications
No Active Medications Found.

SO Note Written by PETO,GENEIL A. @ 19 Aug 2010 1130 PDT
Subjective
Spoke with Cpt Velez-Rivera 4-5806 to advise of concerns about soldier's emotional well-being when he is advised of SM/W's decision to terminate the marriage. CPT advised he has met with SM/W's Command and is aware of the plan, and acknowledges the soldier may struggle emotionally. CPT advised the safety plan is to extend the No-Contact order until 9/1/10 to allow SM/H to PCS (due to report to Polk 9/10/10). Soldier has been advised not to contact FM/W and Command is aware of his attempts to facilitate 3rd party communication and has counseled SM/H against these communications. Discussed SM/H attend Anger Management Thur 8:30 - 10:00 prior to going to CRC as a means of raising his awareness of anger issues he has and a means of ongoing assessement during the transitional stage of separation/divorce.

A/P Last Updated by PETO,GENIEL A @ 19 Aug 2010 1130 PDT
1. PARTNER RELATIONAL PROBLEM

Disposition Last Updated by PETO,GENIEL A @ 19 Aug 2010 1130 PDT
Follow up: as needed in the FAMILY ADVOCACY WACH clinic.
Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By PETO, GENIEL A (FAP CASE MANAGER) @ 19 Aug 2010 1130

Name/SSN: SALEH, GARY WALTER/247633730

		Sex:	M	Sponsor/SSN:	SALEH, GARY WALTER/247633730
FMP/SSN:	**20/247633730**	Tel H:	808-936-6997	Rank:	SPECIALIST
DOB:	**08 Nov 1985**	Tel W:	808-285-9891	Unit:	WH53A0FC
PCat:	A11.2 USA ACTIVE DUTY ENLISTED	CS:		Outpt Rec. Rm:	SB TMC 1 RECORD ROOM
MC Status:		Status:		PCM:	SKEEN,PHILLIP MARK
Insurance:	No			Tel. PCM:	

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HEALTH RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

Patient: **SALEH, GARY WALTER**
Treatment Facility: **WEED ACH**
Patient Status: **Outpatient**

Date: **18 Aug 2010 0730 PDT**
Clinic: **FAMILY ADVOCACY WACH**

Appt Type: **ACUT**
Provider: **PETO,GENEIL A.**

Reason for Appointment: initial
Appointment Comments:
mfh071710

AutoCites Refreshed by PETO,GENIEL A @ 04 Oct 2010 1545 PDT

Family History

- No Family History of marital history (General FHx)
- No Family History of mental illness (not retardation) (General FHx)
- No Family History of alcoholism (General FHx)
- No family history [use for free text] (General FHx)

Social History

No Social History Found.

Active Medications
No Active Medications Found.

SO Note Written by PETO,GENEIL A. @ 12 Oct 2010 1654 PDT
History of present illness

The Patient is a 24 year old male.

He reported: Encounter Background Information: Assessment reference FAP case referral received from MP's 8/16/10.S: Client arrived on time, appropriately groomed, with fair hygiene and normal posture, presenting as friendly and cooperative. Client was alert with normal movement and clear speech. His affect was anxious, but not inappropriate to the circumstance. Client's memory appeared intact and he was oriented X4. No gross abnormalities regarding thought process/content was noted; he was devoid of obvious perceptual disturbances and demonstrated fair reasoning, judgment and insight.

O: Client acknoweldges he is too dependent on his wife due to early life experiences and states, "Since I came back from Iraq I get angry easier".

A: We reviewed confidentiality X3. Client identified the following stressors: Employment (Wife's job upsets her a lot), Pending move (FM/W is not happy about PCSing as only has 8 months left); Loneliness/Isolation (Issue for wife who has close family, but not an issue for client who grew up independent and alone (foster homes)); Medical (Wife underwent recent surgery and had miscarriage) Family Disagreements (Client indicated he defers to his wife as her culture does not typically support female autonomy). Client stated the following with regard to underlying dynamics, issues and concerns in this relationship, "Client stated, "I can tell you what's wrong with me - not having a family around me when I was growoing up and having her and her family makes me feel whole and I want to be with her - she loves me and takes care of me and I want to be with her all the time, that stresses her out". A safety plan was devised regarding the relationship and client's well-being. P: This case meets criteria for FAP and is anticipated to be presented at CRC 9/8/10. A treatment plan will be devised in the interim, and it was suggested to Command soldier may benefit from attending anger management class Thur for 8:30 - 10:00 prior to be adjudicated in part to assist him in identifying unresolved anger and increase awareness regarding how he impacts others, in addition to providing additional support during the anticipated separation from his wife.

Family history

Encounter Background Information:

Regarding family of Origin: Client stated, ""I can tell you what's wrong with me - not having a family around me when I was growoing up and having her and her family makes me feel whole and I want to be with her - she loves me and takes care of me and I want to be with her all the time, that stresses her out".

Substance Use/Abuse: Client reports maternal family history of marijuana use, which he indicated was not bad enough to require treatment. Client reports his step-father consumes alcohol, to an extent that he should recieve treatment.

Mental Illness: Client reports mother has an autistic brother and states his sister who was a "wild child' was hospitalized as a teen for 2 months due to client mother and step-father's inability to control her. Client reports this sister is doing well currently, living in N.Carolina, with 4 children.

Family Interactions during informative years: Client indicates he was raised by his Aunt and Uncle for the first 6 years of his life, as his biological mother was an "escort" and not around much. Client reports his biological mother and biological fahter Jarkke,

Name/SSN: SALEH, GARY WALTER/247633730

		Sex:	M	Sponsor/SSN:	SALEH, GARY WALTER/247633730
FMP/SSN:	20/247633730	Tel H:	808-936-6997	Rank:	SPECIALIST
DOB:	08 Nov 1985	Tel W:	808-285-9891	Unit:	WH53A0FC
PCat:	A11.2 USA ACTIVE DUTY ENLISTED	CS:		Outpt Rec. Rm:	SB TMC 1 RECORD ROOM
MC Status:		Status:		PCM:	SKEEN,PHILLIP MARK
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

had a daughter, his sister, in 1984 and split up after he was concieved but prior to his birth in 1985. Client indicates he did not meet his biological father Jarrk until he was 23 years old. When client turned 6 his bio-mother married Ross, who was, "a good guy". The family moved into Ross's house and he had the opprotunity to become involved in sports at school and states, "Life was great until I turned 12 or 13 and my mom and Ross split up and then it all ended". He reports when they moved out of Ross's house his mother started "escorting" again. Client reports he stayed with friends and his sister for the next 3 years of his life, 12-15 and at 15 bio-mother sent him to live with his sister and stated, "She just never had me come home again". Client reprots that at 16 years of age sister put client in foster care when, 'Her boydriend got tired of him being around". He reports the initial foster home was good for the first 6 months, but he was removed as a result of negligence on behalf of the foster parents when he got stung by bees (he was allergic) when he ws moving the lawn. Client reports he went from there to a group home until he was 18 years of age.

Discipline: Client reports he was paddled by his aunt or uncle,when he was younger and was unable to recall any significant instances where he was abused in any way.

Current contact with family of Origin: Biological Mother - Client reports his mother continues to "escort" and states,"She uses this as a crutch, and threatens that if I don't give her money she will have to escort and that it will be my fault". Biological Father: Client reports he first met his father last year. Client was told by bio-Mom that his father was physically abusive and attempted to "keep my sister away from my Mom", however, the Mother eventually "got her back", but client does not know how this transpired. Client reports his father was unaware of his existence and acutally had a DNA test done which proved he was the biological father. Client reports that when he met his father he got to meet 9 other siblings he never know about. Client did not elaborate on his relationship with his father, however, his father is a Palestinian of Arabic descent and over the past year client has begun to refer to himself as a Arabic, which is a stressor from the SM/ W perspective as she is Arabic and is offended by him taking on his father's identity superficially. This is significant due to the clinet's lack of internal identify and sense of self, which greatly impacts his interpersonal relationships in a variety of contexts. Client also indicates to others that he has this close, recirprocal relationship with his family members, which is not true, which also creates a sense of frustration in SM/W who enjoys close family ties with family members.

Other

Safety Plan: Client indicates he expects to reunify with SM/W and acknowledges that a 6 month separation while they work on their issues might be appropriate. He also indicates a willingness to faciliate marriage couseling but states, 'I don't know if she will do it". Client admitted he has told people 'he couldn't deal with stuff like, "me losing my wife means I have nothing to live for; but if we were without one another I think I would shut down and not be able to work or care about school. Without her I cannot function in my life; before her I was depressed". Client also indicated that without his wife he, "Would be playing video games and not reaching promotable status". Client reported at the end of this assessment however, that despite indicating he would not be able to cope if his wife left him, he would not harm himself and would find a way to deal with the pain, and indicated a willingness to utilize FAP, BH or ER should he expereince suicidal ideation.

SI/HI Assessment: Chronic risk-factor(s) - Perpetuating Risk Factors - permanent and non-modifiable:Male, anticipating separation/divorce; Parental History of substance abuse; History of impulsive/reckless bahaviors, History of Violent behaviors. Predisposing and Potentially Modifiable Risk Factors: Axis II characteristics; low self-esteemAcute risk-factor(s): Relationship stressors; Anticipating separation/divorce; denied current suicidal ideation but endorses past suicidal ideation with no plan, and indicates that he would be more liekity to exhibit depresssive symptomology such as isolation than attempt suicide currently; Psychological Pain in response to the loss of relationship which he endorses as the only thing thing that keeps him going; Unresolved anger; Poor Problem-solving skills; Cognitive Constriction, Few reasons for living/Loss of meaningMitigating factor(s):denied suicidal ideation, no recent history of suicide attempts, no previous history of suicide attempts, absence of alcohol/substance abuse, absence of psychosis, no weapon in the home, willingness to engage in counseling.Overall Risk of Self-Harm (or harm to others): MODERATE risk at this time..

A/P Last Updated by PETO,GENIEL A @ 19 Aug 2010 1119 PDT

1. Partner relational problem

Procedure(s): -Social Work Individual Outpatient Counseling 75-80 Minutes x 1

Disposition Last Updated by PETO,GENIEL A @ 19 Aug 2010 1120 PDT

Released w/o Limitations

Follow up: as needed in the FAMILY ADVOCACY WACH clinic.

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

Signed By PETO, GENIEL A (FAP CASE MANAGER) @ 13 Oct 2010 1603

CHANGE HISTORY

The following SO Note Was Overwritten by PETO,GENIEL A @ 12 Oct 2010 1654 PDT:

SO Note Written by PETO,GENEIL A. @ 19 Aug 2010 0623 PDT

History of present Illness

The Patient is a 24 year old male.

He reported: Encounter Background Information: Assessment reference FAP case referral received from MP's 8/16/10.S: Client arrived on time, appropriately groomed, with fair hygiene and normal posture, presenting as friendly and cooperative. Client was alert with normal movement and clear speech. His affect was anxious, but not inappropriate to the circumstance. Client's memory appeared intact and he was oriented X4. No gross abnormalities regarding thought process/content was noted; he was devoid of obvious perceptual disturbances and demonstrated fair reasoning, judgment and insight.

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HEALTH RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

18 Aug 2010 0858
Facility: Weed ACH Fort Irwin, CA **Clinic: FAMILY ADVOCACY WACH** **Provider: PETO,GENEIL A.**

O: Client acknoweldges he is too dependent on his wife due to early life experiences and states, "Since I came back from Iraq I get angry easier".

A: We reviewed confidentiality X3. Client identified the following stressors: Employment (Wife's job upsets her a lot), Pending move (FM/W is not happy about PCSing as only has 8 months left); Loneliness/Isolation (Issue for wife who has close family, but not an issue for client who grew up independent and alone (foster homes)); Medical (Wife underwent recent surgery and had miscarriage) Family Disagreements (Client indicated he defers to his wife as her culture does not typically support female autonomy). Client stated the following with regard to underlying dynamics, issues and concerns in this relationship, "Client stated, "I can tell you what's wrong with me - not having a family around me when I was growoing up and having her and her family makes me feel whole and I want to be with her - she loves me and takes care of me and I want to be with her all the time, that stresses her out". A safety plan was devised regarding the relationship and client's well-being. P: This case meets criteria for FAP and is anticipated to be presented at CRC 9/8/10. A treatment plan will be devised in the interim, and it was suggested to Command soldier may benefit from attending anger management class Thur for 8:30 - 10:00 prior to be adjudicated in part to assist him in identifying unresolved anger and increase awareness regarding how he impacts others, in addition to providing additional support during the anticipated separation from his wife.

<u>Family history</u>

Encounter Background Information:

Regarding family of Origin: Client stated, ""I can tell you what's wrong with me - not having a family around me when I was growoing up and having her and her family makes me feel whole and I want to be with her - she loves me and takes care of me and I want to be with her all the time, that stresses her out".

Substance Use/Abuse: Client reports maternal family history of marijuana use, which he indicated was not bad enough to require treatment. Client reports his step-father consumes alcohol, to an extent that he should recieve treatment.

Mental Illness: Client reports mother has an autistic brother and states his sister who was a "wild child' was hospitalized as a teen for 2 months due to client mother and step-father's inability to control her. Client reports this sister is doing well currently, living in N.Carolina, with 4 children.

Family Interactions during informative years: Client indicates he was raised by his Aunt and Uncle for the first 6 years of his life, as his biological mother was an "escort" and not around much. Client reports his biological mother and biological fahter Jarkke, had a daughter, his sister, in 1984 and split up after he was concieved but prior to his birth in 1985. Client indicates he did not meet his biological father Jarrk until he was 23 years old. When client turned 6 his bio-mother married Ross, who was, "a good guy". The family moved into Ross's house and he had the opprotunity to become involved in sports at school and states, "Life was great until I turned 12 or 13 and my mom and Ross split up and then it all ended". He reports when they moved out of Ross's house his mother started "escorting" again. Client reports he stayed with friends and his sister for the next 3 years of his life, 12-15 and at 15 bio-mother sent him to live with his sister and stated, "She just never had me come home again". Client reprots that at 16 years of age sister put client in foster care when, 'Her boydriend got tired of him being around". He reports the initial foster home was good for the first 6 months, but he was removed as a result of negligence on behalf of the foster parents when he got stung by bees (he was allergic) when he ws moving the lawn. Client reports he went from there to a group home until he was 18 years of age.

Discipline: Client reports he was paddled by his aunt or uncle,when he was younger and was unable to recall any significant instances where he was abused in any way.

Current contact with family of Origin: Biological Mother - Client reports his mother continues to "escort" and states,"She uses this as a crutch, and threatens that if I don't give her money she will have to escort and that it will be my fault". Biological Father: Client reports he first met his father last year. Client was told by bio-Mom that his father was physically abusive and attempted to "keep my sister away from my Mom", however, the Mother eventually "got her back", but client does not know how this transpired. Client reports his father was unaware of his existence and acutally had a DNA test done which proved he was the biological father. Client reports that when he met his father he got to meet 9 other siblings he never know about. Client did not elaborate on his relationship with his father, however, his father is a Palestinian of Arabic descent and over the past year client has begun to refer to himself as a Arabic, which is a stressor from the SM/ W perspective as she is Arabic and is offended by him taking on his father's identity superficially. This is significant due to the clinet's lack of internal identify and sense of self, which greatly impacts his interpersonal relationships in a variety of contexts. Client also indicates to others that he has this close, recirprocal relationship with his family members, which is not true, which also creates a sense of frustration in SM/W who enjoys close family ties with family members.

<u>Other</u>

Safety Plan: Client indicates he expects to reunify with SM/W and acknowledges that a 6 month separation while they work on their issues might be appropriate. He also indicates a willingness to faciliate marriage couseling but states, 'I don't know if she will do it". Client admitted he has told people 'he couldn't deal with stuff' like, "me losing my wife means I have nothing to live for; but if we were without one another I think I would shut down and not be able to work or care about school. Without her I cannot function in my life; before her I was depressed". Client also indicated that without his wife he, "Would be playing video games and not reaching promotable status". Client reported at the end of this assessment however, that despite indicating he would not be able to cope if his wife left him, he would not harm himself and would find a way to deal with the pain, and indicated a willingness to utilize FAP, BH or ER should he expereince suicidal ideation.

SI/HI Assessment: Chronic risk-factor(s) - Perpetuating Risk Factors - permanent and non-modifiable:Male, anticipating separation/divorce; Parental History of substance abuse; History of impulsive/reckless behaviors, History of Violent behaviors. Predisposing and Potentially Modifiable Risk Factors: Axis II characteristics; low self-esteemAcute risk-factor(s): Relationship stressors; Anticipating separation/divorce; denied current suicidal ideation but endorses past suicidal ideation with no plan, and indicates that he would be more liekity to exhibit depressive symptomology such as isolation than attempt suicide currently; Psychological Pain in response to the loss of relationship which he endorses as the only thing thing that keeps him going; Unresolved anger; Poor Problem-solving skills; Cognitive Constriction, Few reasons for living/Loss of meaningMitigating factor(s):denied suicidal ideation, no recent history of suicide attempts, no previous history of suicide attempts, absence of alcohol/substance abuse, absence of psychosis, no weapon in the home, willingness to engage in counseling. Overall Risk of Self-Harm (or harm to others): MODERATE risk at this time..

<u>The following Signature(s) No Longer Applies because this Encounter Was Opened for Amendment by PETO,GENIEL A @ 12 Oct 2010 1654 PDT:</u>

Signed PETO, GENEIL A. (FAP CASE MANAGER) @ 04 Oct 2010 1546

<u>The following AutoCites Were Overwritten by PETO,GENIEL A @ 04 Oct 2010 1545 PDT:</u>

<u>AutoCites</u> <u>Refreshed by PETO,GENIEL A @ 19 Aug 2010 0623 PDT</u>

Family History

- No Family History of marital history (General FHx)
- No Family History of mental illness (not retardation) (General FHx)
- No Family History of alcoholism (General FHx)
- No family history [use for free text] (General FHx)

Social History

No Social History Found.

Active Medications

No Active Medications Found.

<u>The following Signature(s) No Longer Applies because this Encounter Was Opened for Amendment by PETO,GENIEL A @ 04 Oct 2010 0927 PDT:</u>

Signed PETO, GENEIL A. (FAP CASE MANAGER) @ 19 Aug 2010 1120

Name/SSN: SALEH, GARY WALTER/247633730

		Sex:	M	Sponsor/SSN:	SALEH, GARY WALTER/247633730
FMP/SSN:	**20/247633730**	Tel H:	808-936-6997	Rank:	SPECIALIST
DOB:	**08 Nov 1985**	Tel W:	808-285-9891	Unit:	WH53A0FC
PCat:	A11.2 USA ACTIVE DUTY ENLISTED	CS:		Outpt Rec. Rm:	SB TMC 1 RECORD ROOM
MC Status:		Status:		PCM:	SKEEN,PHILLIP MARK
Insurance:	No			Tel. PCM:	

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HEALTH RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

Patient: **SALEH, GARY WALTER**
Treatment Facility: **WEED ACH**
Patient Status: **Outpatient**

Date: **17 Aug 2010 1419 PDT**
Clinic: **FAMILY ADVOCACY WACH**

Appt Type: **T-CON***
Provider: **PETO,GENEIL A.**
Call Back Phone: **(808)-936-6997**

Reason for Telephone Consult: F/U to FAP case

AutoCites Refreshed by PETO,GENIEL A @ 17 Aug 2010 1431 PDT

Family History
- No Family History of marital history (General FHx)
- No Family History of mental illness (not retardation) (General FHx)
- No Family History of alcoholism (General FHx)
- No family history [use for free text] (General FHx)

Social History

No Social History Found.

Active Medications
No Active Medications Found.

SO Note Written by PETO,GENEIL A. @ 17 Aug 2010 1436 PDT
Subjective
Received call from MP's on 16 Aug 2010 at 20:58, regarding a physical altercation that occurred at the couple's home at 19:22 this evening. MP's report a verbal altercation turned physical when SM/H punched SM/W in the stomach multiple times. Due to having undergone recent abdominal surgery SM/W was taken to the ER by ambulance. Platoon SGT Williams put a 72 hour no contact order in place. Attempt to contact SM/H 8/17 was unsuccessful. Made contact with 1SGT Castro who advised SM/H is in school until 17:00 and will have him report for FAP assessment 8/18 at 7:30.

A/P Last Updated by PETO,GENIEL A @ 17 Aug 2010 1436 PDT
1. PARTNER RELATIONAL PROBLEM

Disposition Last Updated by PETO,GENIEL A @ 17 Aug 2010 1436 PDT
Follow up: as needed in 1 day(s) in the FAMILY ADVOCACY WACH clinic or sooner if there are problems.
Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By PETO, GENIEL A (FAP CASE MANAGER) @ 17 Aug 2010 1436

Name/SSN: SALEH, GARY WALTER/247633730

		Sex:	M	Sponsor/SSN:	SALEH, GARY WALTER/247633730
FMP/SSN:	**20/247633730**	Tel H:	808-936-6997	Rank:	SPECIALIST
DOB:	**08 Nov 1985**	Tel W:	808-285-9891	Unit:	WH53A0FC
PCat:	A11.2 USA ACTIVE DUTY ENLISTED	CS:		Outpt Rec. Rm:	SB TMC 1 RECORD ROOM
MC Status:		Status:		PCM:	SKEEN,PHILLIP MARK
Insurance:	No			Tel. PCM:	

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HEALTH RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

Patient: **SALEH, GARY WALTER**
Treatment Facility: **COMMUNITY MENTAL HEALTH SERVICE FT. IRWIN**
Patient Status: **Outpatient**

Date: **04 Aug 2009 1000 PDT**
Clinic: **SOCIAL WORK WACH**

Appt Type: **EST**
Provider: **ALDERMAN-SCHAEFER,SUSAN M**

Reason for Appointment: f/u
Appointment Comments:
llcbw 21jul

AutoCites Refreshed by ALDERMAN-SCHAEFER,SUSAN M @ 04 Aug 2009 1230 PDT

Problems

Chronic:
- Acute reaction to stress with mixed disorders
- Testicular neoplasm
- Nicotine dependence
- Preventive medicine new patient evaluation adult 18-39
- Need for typhoid vaccination
- Visit for: administrative purposes
- Visit for: military services physical
- Visit for: occupational health/fitness exam
- Nonvenomous insect bite

Allergies
- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
OXYCODONE HCL/ACETAMINOPHEN, 5MG-325MG, TABLET, ORAL	Active	T1 TAB PO TID #30 RF0	NR	29 Jul 2009
TRAMADOL HCL, 50MG, TABLET, ORAL	Active	T1 TAB PO TID #30 RF0	NR	27 Jul 2009
Silver Sulfadiazine 1%, Cream, Topical	Active	APPLY IN 1/16 INCH LAYER ONCE TO TWICE A DAY	NR	24 Jul 2009
NAPROXEN, 250MG, TABLET, ORAL	Active	T1 TAB PO BID	NR	15 Jul 2009
Nicotine 7mg/24hr, Transdermal system, Transdermal	Active	APPLY ONE PATCH PER DAY FOR 7 DAYS #7 RF1	1 of 1	15 Apr 2009
Nicotine 14mg/24hr, Transdermal system, Transdermal	Active	APPLY 1 PATCH TO CLEAN, DRY, HAIR-FREE AREA OF THE SKIN QD F7 #7 RF1	1 of 1	15 Apr 2009
Nicotine 21mg/24hr, Transdermal system, Transdermal	Active	APPLY 1 PATCH TO CLEAN, DRY, HAIR-FREE AREA OF THE SKIN QD F7D	1 of 1	08 Apr 2009
Bupropion Hydrochloride 150mg, (Zyban), Extended release tablet, Oral	Active	T1 TAB PO QAM F3 THEN 1 TAB BID	4 of 4	08 Apr 2009
VARENICLINE TARTRATE, 1MG, TABLET, ORAL	Active	T 1 TAB PO BID AS DIRECTED #1 RF4	4 of 4	03 Nov 2008

SO Note Written by ALDERMAN-SCHAEFER,SUSAN M @ 04 Aug 2009 1230 PDT

Chief complaint

The Chief Complaint is: I am having anxiety, sleeplessness and startle very easily since EOD explosion a few days ago.

Reason for Visit

Follow Up
:60 Min.

History of present illness

The Patient is a 23 year old male.

Client was involved in a blast explosion while training over past week and burned on hand severely and face and nose also burned and bandaged. Client unable to write paperwork and took with him for someone to help him complete social history. He was able to

Name/SSN: SALEH, GARY WALTER/247633730

		Sex:	M	Sponsor/SSN:	SALEH, GARY WALTER/247633730
FMP/SSN:	20/247633730	Tel H:	808-936-6997	Rank:	SPECIALIST
DOB:	08 Nov 1985	Tel W:	808-285-9891	Unit:	WH53A0FC
PCat:	A11.2 USA ACTIVE DUTY ENLISTED	CS:		Outpt Rec. Rm:	SB TMC 1 RECORD ROOM
MC Status:		Status:		PCM:	SKEEN,PHILLIP MARK
Insurance:	No			Tel. PCM:	

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HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE

04 Aug 2009 0942
Facility: Weed ACH Fort Irwin, CA **Clinic: Social Work Weed ACH** **Provider: ALDERMAN-SCHAEFER, SUSAN M**

X and initial Consent to Treat document today. Client states he was given a sleep medication but remains unable to go to sleep. He states when he begins to fall asleep he is awakened by nightmares of event that happened to him described above.~

Problem(s)
~1. Nightmares ~ 2. Not sleeping with Medication ~3. Severe Startle Response~4. ~
Objective(s) (by problem number)~1. Intake~2. Further Appt~3. Refer to medical for evaluation of further medication to treat symptoms of anxiety and startle response and soothe sleep issue~4. ~
Interventions (by problem number) ~1. Walk In appt ~2. Intake appt~3. medical referral~4. further counseling~.

Subjective
Client presented to appt today and reports feeling better (bandages are off hand and treatment to restore movement and range of motion continue with medical doctors. Client reports likely he will change units and feels okay about that. Client states that he would like to continue counseling for a while and will make appt for 2 weeks with provider.

Physical findings
General appearance:
° Normal. ° Awake. ° Alert. ° Oriented to time, place, and person. ° Active. ° In no acute distress.
Neurological:
° No hallucinations. ° Mental status was normal.
Psychiatric Exam:
Mood: ° Euthymic.
Affect: ° Normal.
Thought Processes: ° Not impaired.
Thought Content: ° Revealed no impairment. ° Insight was intact. ° No suicidal ideation. ° No homicidal ideations.

A/P Written by ALDERMAN-SCHAEFER,SUSAN M @ 04 Aug 2009 1234 PDT
1. ACUTE REACTION TO STRESS WITH MIXED DISORDERS
Procedure(s): -Social Work Individual Outpatient Counseling 45-50 Minutes x 1

Disposition Written by ALDERMAN-SCHAEFER,SUSAN M @ 04 Aug 2009 1235 PDT
Released w/o Limitations

Signed By ALDERMAN-SCHAEFER, SUSAN M (Social Worker, Weed ACH Fort Irwin, CA) @ 04 Aug 2009 1235

Name/SSN: SALEH, GARY WALTER/247633730

		Sex:	M	Sponsor/SSN:	SALEH, GARY WALTER/247633730
FMP/SSN:	20/247633730	Tel H:	808-936-6997	Rank:	SPECIALIST
DOB:	08 Nov 1985	Tel W:	808-285-9891	Unit:	WH53A0FC
PCat:	A11.2 USA ACTIVE DUTY ENLISTED	CS:		Outpt Rec. Rm:	SB TMC 1 RECORD ROOM
MC Status:		Status:		PCM:	SKEEN,PHILLIP MARK
Insurance:	No			Tel. PCM:	

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HEALTH RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

Patient: **SALEH, GARY WALTER**
Treatment Facility: **COMMUNITY MENTAL HEALTH SERVICE FT. IRWIN**
Patient Status: **Outpatient**

Date: **21 Jul 2009 0800 PDT**
Clinic: **SOCIAL WORK WACH**

Appt Type: **WELL**
Provider: **ALDERMAN-SCHAEFER,SUSAN M**

Reason for Appointment: f/u
Appointment Comments:
slr 17 Jul

AutoCites Refreshed by ALDERMAN-SCHAEFER,SUSAN M @ 22 Jul 2009 1001 PDT

Problems
Chronic:
- Acute reaction to stress with mixed disorders
- Testicular neoplasm
- Nicotine dependence
- Preveritive medicine new patient evaluation adult 18-39
- Need for typhoid vaccination
- Visit for: administrative purposes
- Visit for: military services physical
- Visit for: occupational health/fitness exam
- Nonvenomous insect bite

Allergies
- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
OXYCODONE HCL/ACETAMINOPHEN, 5MG-325MG, TABLET, ORAL	Active	T1 TAB PO TID	NR	22 Jul 2009
NAPROXEN, 250MG, TABLET, ORAL	Active	T1 TAB PO BID	NR	15 Jul 2009
Nicotine 7mg/24hr, Transdermal system, Transdermal	Active	APPLY ONE PATCH PER DAY FOR 7 DAYS #7 RF1	1 of 1	15 Apr 2009
Nicotine 14mg/24hr, Transdermal system, Transdermal	Active	APPLY 1 PATCH TO CLEAN, DRY, HAIR-FREE AREA OF THE SKIN QD F7 #7 RF1	1 of 1	15 Apr 2009
Nicotine 21mg/24hr, Transdermal system, Transdermal	Active	APPLY 1 PATCH TO CLEAN, DRY, HAIR-FREE AREA OF THE SKIN QD F7D	1 of 1	08 Apr 2009
Bupropion Hydrochloride 150mg, (Zyban), Extended release tablet, Oral	Active	T1 TAB PO QAM F3 THEN 1 TAB BID	4 of 4	08 Apr 2009
VARENICLINE TARTRATE, 1MG, TABLET, ORAL	Active	T 1 TAB PO BID AS DIRECTED #1 RF4	4 of 4	03 Nov 2008

SO Note Written by ALDERMAN-SCHAEFER,SUSAN M @ 22 Jul 2009 1002 PDT

Chief complaint
The Chief Complaint is: I am having anxiety, sleeplessness and startle very easily since EOD explosion a few days ago.

Reason for Visit
Follow Up
:60 Min.

History of present illness
The Patient is a 23 year old male.
He reported: No sleep disturbances, no loss of interest in activities, and no anhedonia. Increased energy.

Client was involved in a blast explosion while training over past week and burned on hand severely and face and nose also burned and bandaged. Client unable to write paperwork and took with him for someone to help him complete social history. He was able to X and initial Consent to Treat document today. Client states he was given a sleep medication but remains unable to go to sleep. He states when he begins to fall asleep he is awakened by nightmares of event that happened to him described above.~

Name/SSN: SALEH, GARY WALTER/247633730

FMP/SSN:	20/247633730	Sex:	M	Sponsor/SSN:	SALEH, GARY WALTER/247633730
DOB:	08 Nov 1985	Tel H:	808-936-6997	Rank:	SPECIALIST
PCat:	A11.2 USA ACTIVE DUTY ENLISTED	Tel W:	808-285-9891	Unit:	WH53A0FC
		CS:		Outpt Rec. Rm:	SB TMC 1 RECORD ROOM
MC Status:		Status:		PCM:	SKEEN,PHILLIP MARK
Insurance:	No			Tel. PCM:	

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HEALTH RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

21 Jul 2009 0755
Facility: Weed ACH Fort Irwin, CA **Clinic: Social Work Weed ACH** **Provider: ALDERMAN-SCHAEFER, SUSAN M**

Problem(s)
~1. Nightmares ~ 2. Not sleeping with Medication ~3. Severe Startle Response~4. ~
Objective(s) (by problem number)~1. Intake~2. Further Appt~3. Refer to medical for evaluation of further medication to treat symptoms of anxiety and startle response and soothe sleep issue~4. ~
Interventions (by problem number) ~1. Walk In appt ~2. Intake appt~3. medical referral~4. further counseling~.

Subjective
Client placed on medication to treat symptoms and reports that it has been effective over past few days. Client states feeling better and that most time pain from physical injury feels better.
Client discussed issue that is bothering him and developed plan for improving his situation.

Physical findings
General appearance:
° Normal. ° Awake. ° Alert. ° Oriented to time, place, and person. ° Active. ° In no acute distress.
Neurological:
° No hallucinations. ° Mental status was normal.
Psychiatric Exam:
Mood: ° Euthymic.
Affect: ° Normal.
Thought Processes: ° Not impaired.
Thought Content: ° Revealed no impairment. ° Insight was intact. ° No suicidal ideation. ° No homicidal ideations.

A/P Written by ALDERMAN-SCHAEFER,SUSAN M @ 22 Jul 2009 1009 PDT
1. ACUTE REACTION TO STRESS WITH MIXED DISORDERS
Procedure(s): -Social Work Individual Outpatient Counseling 45-50 Minutes x 1

Disposition Written by ALDERMAN-SCHAEFER,SUSAN M @ 22 Jul 2009 1009 PDT
Released w/o Limitations

Signed By ALDERMAN-SCHAEFER, SUSAN M (Social Worker, Weed ACH Fort Irwin, CA) @ 22 Jul 2009 1009

Name/SSN: SALEH, GARY WALTER/247633730

		Sex:	M	Sponsor/SSN:	SALEH, GARY WALTER/247633730
FMP/SSN:	20/247633730	Tel H:	808-936-6997	Rank:	SPECIALIST
DOB:	08 Nov 1985	Tel W:	808-285-9891	Unit:	WH53A0FC
PCat:	A11.2 USA ACTIVE DUTY ENLISTED	CS:		Outpt Rec. Rm:	SB TMC 1 RECORD ROOM
MC Status:		Status:		PCM:	SKEEN,PHILLIP MARK
Insurance:	No			Tel. PCM:	

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HEALTH RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

Patient: **SALEH, GARY WALTER**
Treatment Facility: **COMMUNITY MENTAL HEALTH SERVICE FT. IRWIN**
Patient Status: **Outpatient**

Date: **17 Jul 2009 0800 PDT**
Clinic: **SOCIAL WORK WACH**

Appt Type: **EST**
Provider:
ALDERMAN-SCHAEFER,SUSAN M

Reason for Appointment: intake
Appointment Comments:
llcbw 16jul

AutoCites Refreshed by ALDERMAN-SCHAEFER,SUSAN M @ 20 Jul 2009 0828 PDT

Problems

Chronic:

- Testicular neoplasm
- Nicotine dependence
- Preventive medicine new patient evaluation adult 18-39
- Need for typhoid vaccination
- Visit for: administrative purposes
- Visit for: military services physical
- Visit for: occupational health/fitness exam
- Nonvenomous insect bite

Allergies

- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
HYDROCODONE BIT/ACETAMINOPHEN, 5MG-500MG, TABLET, ORAL	Active	T1 TAB PO TID FOR PAIN	NR	17 Jul 2009
NAPROXEN, 250MG, TABLET, ORAL	Active	T1 TAB PO BID	NR	15 Jul 2009
Nicotine 7mg/24hr, Transdermal system, Transdermal	Active	APPLY ONE PATCH PER DAY FOR 7 DAYS #7 RF1	1 of 1	15 Apr 2009
Nicotine 14mg/24hr, Transdermal system, Transdermal	Active	APPLY 1 PATCH TO CLEAN, DRY, HAIR-FREE AREA OF THE SKIN QD F7 #7 RF1	1 of 1	15 Apr 2009
Nicotine 21mg/24hr, Transdermal system, Transdermal	Active	APPLY 1 PATCH TO CLEAN, DRY, HAIR-FREE AREA OF THE SKIN QD F7D	1 of 1	08 Apr 2009
Bupropion Hydrochloride 150mg, (Zyban), Extended release tablet, Oral	Active	T1 TAB PO QAM F3 THEN 1 TAB BID	4 of 4	08 Apr 2009
VARENICLINE TARTRATE, 1MG, TABLET, ORAL	Active	T 1 TAB PO BID AS DIRECTED #1 RF4	4 of 4	03 Nov 2008

SO Note Written by ALDERMAN-SCHAEFER,SUSAN M @ 20 Jul 2009 0828 PDT

Chief complaint
The Chief Complaint is: I am having anxiety, sleeplessness and startle very easily since EOD explosion a few days ago.

Reason for Visit
Intake:60 Min.

Referred here
By Command [ ], Self [X
], Emergency Department [ ], Medical [ ], Legal [ ], Other [ ].

History of present illness
The Patient is a 23 year old male.
He reported: Military service in the Army and currently on active duty.
Anxiety, sleep disturbances, loss of interest in activities, anhedonia, and increased energy.

Client was involved in a blast explosion while training over past week and burned on hand severely and face and nose also burned and bandaged. Client unable to write paperwork and took with him for someone to help him complete social history. He was able to X and initial Consent to Treat document today. Client states he was given a sleep medication but remains unable to go to sleep. He states when he begins to fall asleep he is awakened by nightmares of event that happened to him described above.
Visit related to Deployment No [X

Name/SSN: SALEH, GARY WALTER/247633730

FMP/SSN:	**20/247633730**	Sex:	**M**	Sponsor/SSN:	SALEH, GARY WALTER/247633730
DOB:	**08 Nov 1985**	Tel H:	808-936-6997	Rank:	SPECIALIST
PCat:	A11.2 USA ACTIVE DUTY ENLISTED	Tel W:	808-285-9891	Unit:	WH53A0FC
MC Status:		CS:		Outpt Rec. Rm:	SB TMC 1 RECORD ROOM
Insurance:	No	Status:		PCM:	SKEEN,PHILLIP MARK
				Tel. PCM:	

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HEALTH RECORD | CHRONOLOGICAL RECORD OF MEDICAL CARE

17 Jul 2009 0751
Facility: Weed ACH Fort Irwin, CA Clinic: Social Work Weed ACH Provider: ALDERMAN-SCHAEFER, SUSAN M

], Yes [ ], Details [ ].
Past medical/surgical history
Reported History:
Medical: Past medical history was reported by the patient Medical Problems: Yes[ ], No [X], Details [ ]
Past Surgeries: Yes [ ], No [X
], Details [ ].
Reported medications: Not taking OTC medications.
Previous therapy
No history of psychiatric therapy; No history of herbal medicines
Personal history
Personal history: No recent legal problems.
Behavioral history: No caffeine use.
Alcohol: No consumption of alcohol.
Drug use: Not using drugs.
Home environment: No difficulty understanding spoken English and no difficulty reading English. Native language English. The cultural background Caucasian.
Abuse / neglect: No abuse/neglect and no sexual contact or exposure without consent.
Work: No work history reported.
Family: No remarkable family social history Current living situation? [In Barracks], Current family constellation? [Self
].
Functional status: Psychosocial support is sufficient.
Family history
Medical Problems: [no
]
No alcoholism
No mental illness (not retardation) No [ ], Yes [ ], Details [ ]
No remarkable marital history.
Subjective
Limits of Confidentiality Reviewed with patient, patient verbally acknowledged understanding and signature obtained..
Review of systems
Systemic symptoms: Not feeling tired (fatigue).
Gastrointestinal symptoms: Normal appetite.
Neurological symptoms: No decrease in concentrating ability.
Psychological symptoms: No depression, a desire to continue living, and no previous suicide attempt. No violent behavior, no low self-esteem, not feeling guilty, and not being upset by problems at home or work. No disturbing or unusual thoughts, feelings, or sensations and no interpersonal relationship problems.
Physical findings
Judgment: Good [X, Fair [ ], Poor [ ] ~~TREATMENT PLAN (JCAHO Std. PC.4.10) ~
Patient Strengths: Employed, Educated; Motivated for Treatment ~
Barriers to treatment: Soldier's Schedule for Work in his unit ~
Problem(s)~1. Nightmares ~2. Not sleeping with Medication ~3. Severe Startle Response~4. ~
Objective(s) (by problem number)~1. Intake~2. Further Appt~3. Refer to medical for evaluation of further medication to treat symptoms of anxiety and startle response and soothe sleep issue~4. ~
Interventions (by problem number) ~1. Walk In appt ~2. Intake appt~3. medical referral~4. further counseling~.
General appearance:
° Normal. ° Awake. ° Alert. ° Oriented to time, place, and person. ° Active. ° In no acute distress.
Neurological:
° No hallucinations. ° Mental status was normal.
Speech: ° Normal. ° Sufficient nonverbal communication skills were demonstrated.
Psychiatric Exam:
Appearance: ° Normal.
Demonstrated Behavior: ° Behavior demonstrated no abnormalities.
Attitude: ° Not abnormal.
Mood: ° Euthymic.
Affect: ° Normal.
Thought Processes: ° Not impaired.
Thought Content: ° Revealed no impairment . ° Insight was intact. ° No suicidal ideation. ° No suicidal plans. ° No suicidal intent. ° No homicidal ideations. ° No homicidal plans. ° No homicidal intent.

A/P Written by ALDERMAN-SCHAEFER,SUSAN M @ 20 Jul 2009 0956 PDT
1. ACUTE REACTION TO STRESS WITH MIXED DISORDERS
Procedure(s): -Social Work Individual Outpatient Counseling 45-50 Minutes x 1

Name/SSN: SALEH, GARY WALTER/247633730

		Sex:	M	Sponsor/SSN:	SALEH, GARY WALTER/247633730
FMP/SSN:	20/247633730	Tel H:	808-936-6997	Rank:	SPECIALIST
DOB:	08 Nov 1985	Tel W:	808-285-9891	Unit:	WH53A0FC
PCat:	A11.2 USA ACTIVE DUTY ENLISTED	CS:		Outpt Rec. Rm:	SB TMC 1 RECORD ROOM
MC Status:		Status:		PCM:	SKEEN,PHILLIP MARK
Insurance:	No			Tel. PCM:	

CHRONOLOGICAL RECORD OF MEDICAL CARE
For Official Use Only/Law Enforcement Sensitive
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STANDARD FORM 600 (REV. 5)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE

17 Jul 2009 0751
Facility: Weed ACH Fort Irwin, CA **Clinic: Social Work Weed ACH** **Provider: ALDERMAN-SCHAEFER, SUSAN M**

Disposition Written by ALDERMAN-SCHAEFER,SUSAN M @ 20 Jul 2009 0956 PDT
Released w/o Limitations

Signed By ALDERMAN-SCHAEFER, SUSAN M (Social Worker, Weed ACH Fort Irwin, CA) @ 20 Jul 2009 0957

Name/SSN: SALEH, GARY WALTER/247633730

		Sex:	M	Sponsor/SSN:	SALEH, GARY WALTER/247633730
FMP/SSN:	20/247633730	Tel H:	808-936-6997	Rank:	SPECIALIST
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