Mental Health Assessment for Adults

I. Personal Information:

Name: Emma Thompson

Date of Birth: May 15, 1985

Gender: Female

Address: 123 Serenity Lane, Cityville, State

Phone Number: (555) 555-1234

Email: emma.thompson@emai

II. Presenting Concerns:

Reason for Seeking Assessment:
Emma is experiencing persistent feelings of sadness and loss of interest in activities she once enjoyed.

Brief History of the Presenting Concerns:
Symptoms began six months ago after the death of her close friend.

Onset and Duration:
Onset was gradual, lasting for six months, with a noticeable decline in mood and energy.

Impact on Daily Functioning:
Emma reports difficulty concentrating at work, disruptions in sleep, and strained interpersonal relationships.

Previous Attempts at Resolution:
Emma has tried self-help strategies, such as journaling and exercise, with limited success.

III. Medical History:

Current Medications:
None

Medical Conditions:
Hyperthyroidism

History of Psychiatric Hospitalizations:
None

Substance Use History:

- Alcohol: Occasional social drinking
- Drugs (Specify): No history of illicit drug use

Family History of Mental Health Disorders:
Father diagnosed with depression

IV. Psychosocial History:

Educational Background:
Bachelor's degree in Psychology

Occupation:
Human Resources Manager

Relationship Status:
Single

Living Situation:
Lives alone in an apartment

Cultural and Religious Influences:
Raised in a Catholic household

V. Mental Status Examination:

Note: This section involves the clinician's observation and assessment of the individual's appearance, behavior, mood, affect, thought process, thought content, perception, cognition, insight, and judgment.

Appearance and Behavior:
Well-groomed but appears fatigued; exhibits slowed motor movements.

Mood and Affect:
Depressed mood; constricted affect.

Thought Process and Content:
Thoughts centered on loss and feelings of worthlessness.

Perception:
No perceptual disturbances reported.

Cognition:

- Orientation:
  Oriented to person, place, and time.

- Memory:
  Reports occasional forgetfulness

- Concentration:
  Difficulty concentrating during assessment

- Insight and Judgment:
  Limited insight into the impact of her symptoms on daily functioning.

VI. Standardized Assessment Tools:

PHQ-9 (Patient Health Questionnaire-9):

- Score: 18 (Moderate to s

GAD-7 (Generalized Anxiety Disorder-7):

- Score: 12 (Moderate anx

MADRS (Montgomery-Åsberg Depression Rating Scale):

- Score: 28 (Severe depres

Other Relevant Assessment Tools (if applicable):
None

VII. Additional Information:

Trauma History:
No reported history of trauma.

Support System:
Limited support; estranged from family; occasional contact with friends.

Stressors and Coping Mechanisms:
Primary stressor is grief; coping mechanisms include exercise and occasional journaling.

Goals for Treatment:
Emma expresses a desire to alleviate symptoms, improve work performance, and rebuild social connections.

VIII. Recommendations and Follow-up:

Initial Treatment Recommendations:
Referral to a psychiatrist for further evaluation; consider antidepressant medication; individual therapy focused on grief and depression.

Referrals (if needed):
Psychiatry for medication management; local grief support groups.

Follow-up Plan:
Follow up in two weeks to assess response to medication; schedule regular therapy sessions; encourage ongoing support from friends and exploration of new coping strategies.