NR 546 Week 5 Case Study

Subjective	Objective
The client is a 29-year-old, Latino single male referred by his primary care provider for a psychiatric evaluation at an outpatient clinic. **Client's Chief Complaints:** "I think I might be depressed." **History of Present Illness** The client reports increasingly depressive symptoms with onset 3 months ago. He is experiencing stress related to being unemployed, financial strain and needing to sell his home quickly because he cannot afford the mortgage. He reports depressed mood, low energy, low motivation, anhedonia, poor concentration, loneliness, low self- esteem, hopelessness, and decreased appetite with 12 lb. weight loss over the past month. He reports difficulty falling and staying asleep due to anxiety and restlessness, difficulty making decisions and self-isolation. He endorses anxiety related to the stressors reported above, as manifested by restlessness, worry, and muscle tension. He reports that his current mental state is impeding his ability to apply for new employment and prepare his home for the impending sale. **Past psychiatric history:** no previous history, this is the client's first contact with a mental health provider. **Past Medical History:** childhood asthma, does not use inhaler. **Family History** • Father is alive and well. • Mother is alive, has anxiety "all her life" • One brother aged 24, alive and well **Social History** • Lives alone • single • does not have any friends	**Physical Examination:** Height: 67", weight: 200 lb. General: Well-nourished male appears stated age **Mental status exam:** Appearance: appropriate dress for age and situation, well nourished, eye contact poor, slumped posture Alertness and Orientation: alert, fully oriented to person, place, time, and situation, Behavior: cooperative Speech: soft, flat Mood: depressed Affect: constricted, congruent with stated mood Thought Process: logical, linear Thought content: Self-defeating thoughts, endorses thoughts suggestive of low self-worth. No thoughts of suicide, self-harm, or passive death wish Perceptions: No evidence of psychosis, not responding to internal stimuli, reports auditory hallucinations. Memory: Recent and remote WNL Judgement/Insight: Insight is fair, Judgement is fair Attention and observed intellectual functioning: Attention intact for purpose of assessment. Able to follow questioning. Fund of knowledge: Good general fund of knowledge and vocabulary Musculoskeletal: normal gait