

Food and Drug Administration
Center for Food Safety and Applied Nutrition
Office of Special Nutritionals

ARMS#

13072



3 - OUTPATIENT

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CC# EDR-2789
CFSAN Project #13072
11/23/98 JB
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PATIENT INFORMATION SHEET

To our patients: Please complete this information as *best as you are able*. We appreciate your willingness to cooperate in helping us obtain your history. *Thank you for printing.*

Office Use: Patient File # [redacted]

Full Name: [redacted]	Date: [redacted]	Sex: <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female
Address: [redacted]		
Your Social Security Number: [redacted]	Telephone: [redacted]	
Responsible Party Soc. Sec. #: [redacted]	Race: _____	
Date of Birth: [redacted]	Age: <u>15</u>	Marital Status: <u>Single</u>
Employer's Name: <u>none</u>	Employer's Telephone Number: <u>none</u>	
Employer's Address: <u>N/A</u>		
Name of family/relative to contact in case of emergency: [redacted]	Relationship: <u>Parents</u>	
Relative's Address: [redacted]		
How did you hear about us? (who referred you) [redacted]		
INSURANCE SECTION: Please list all insurances and give cards to the secretary		
Do you have Medicare? (check one) Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Medicare #: _____ Eff. Date: _____	
If you have Medicare, who pays the premium? (check one) I pay <input type="checkbox"/> my employer pays <input checked="" type="checkbox"/>		
Primary Insurance: [redacted]	[redacted]	
Second Insurance: _____	_____	
Does your insurance company require pre-authorization?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

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1 please turn to next page and continue

In order for the doctor to get better acquainted with you, please fill in the following information:

1. **Problem:** (Please write in your own words the reason(s) you are seeing a psychiatrist.) FAMILY PROBLEMS, DEPRESSION (me)

2. **Prior Mental Health History:**
Have you ever seen a psychiatrist, therapist or counselor? Yes No
If so, give names and dates Mrs. [redacted] periodically during school
Was it helpful, not helpful, or harmful? not helpful
Have you been on medication? (tranquilizers, antidepressants) Yes No
If so, give name of medication and how you responded to it
Adderall - given by [redacted] doctor. Will not take.

3. **Family History:** (circle one)
Do any members of your family see a mental health professional? (uncle) Yes No
Is there alcoholism in the family? great-grandparent, Aunt + Uncle Yes No
Have any members of the family ever committed suicide? Great Grandfather Yes No
Have you been married before? Yes No
If so, how long and please state reasons for it ending _____

Do you have any children? Yes No

Name of Child	Age	Yes	No
_____	_____		
_____	_____		
_____	_____		

Do you have any brothers or sisters? Yes No

Name of Sibling	Age	Yes	No
<u>[redacted]</u>	<u>26 mths.</u>		
_____	_____		
_____	_____		

4. **Social History:**
Education (Circle highest grade completed) K 1 2 3 4 5 6 7 8 9 10 11 12
College 1 2 3 4 +
Are you currently employed Yes No
(Problems related to present job, with other workers, supervisors, length of employment) _____

5. **Military History:**
Have you been in the military? Yes No
If so, give branch of service, dates, rank on discharge, disciplinary action, any disability: _____

6. **Legal History:**
Have you ever been arrested?
Do you have any legal problems?

Yes No
Yes No

7. **Medical History:**

List allergies, if any: (Seasonal) Yes No
Are you on medication for a medical condition (ex: insulin) _____
Names and dosages of all current medications _____

Have you had any surgery? Yes No
If so, give approximate year and name of procedure (ex: appendix, tonsils, openheart, etc) _____

List all medical conditions (ex: diabetes, heart disease, high blood pressure, etc) N/A

Primary Care Doctor's Name _____
Address and Phone # if known _____
Birth difficulties, illnesses, development delays or lags (for children only) N/A

Have you ever had any of the following symptoms or difficulties?

- | | |
|---|---|
| 1. Repeated headaches | Yes <input checked="" type="radio"/> No <input type="radio"/> |
| 2. Dizziness or loss of balance <u>light-headed</u> | Yes <input checked="" type="radio"/> No <input type="radio"/> |
| 3. Blurring of vision | Yes <input type="radio"/> No <input checked="" type="radio"/> |
| 4. Epilepsy or seizures | Yes <input type="radio"/> No <input checked="" type="radio"/> |
| 5. Head injury | Yes <input type="radio"/> No <input checked="" type="radio"/> |
| 6. Back injury | Yes <input type="radio"/> No <input checked="" type="radio"/> |
| 7. Loss of strength or loss of sensation in part of your body | Yes <input type="radio"/> No <input checked="" type="radio"/> |
| 8. Excessive use of alcohol | Yes <input type="radio"/> No <input checked="" type="radio"/> |
| 9. Drug use (heroin, cocaine, marijuana, barbiturates, etc) | Yes <input type="radio"/> No <input checked="" type="radio"/> |
| 10. Excessive use of prescription medicine (Valium, sleeping pills) | Yes <input type="radio"/> No <input checked="" type="radio"/> |
| 11. Glaucoma | Yes <input type="radio"/> No <input checked="" type="radio"/> |
| 12. Menstrual or prostate difficulties | Yes <input type="radio"/> No <input checked="" type="radio"/> |
| 13. Sexual difficulties | Yes <input type="radio"/> No <input checked="" type="radio"/> |
| 14. Physical abuse | Yes <input type="radio"/> No <input checked="" type="radio"/> |
| 15. Sexual abuse/rape | Yes <input type="radio"/> No <input checked="" type="radio"/> |

8. **Summary:** (Please use this section to indicate what you expect from treatment or to add any information which might help the doctor to better understand your problems.)

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MENTAL STATUS EXAM:

1.) Appearance:	Neat <input checked="" type="checkbox"/>	Minimal Coordination <input type="checkbox"/>	Unkempt <input type="checkbox"/>
2.) Behavior:	Quiet <input type="checkbox"/>	Psychomotor Retardation <input type="checkbox"/>	Agitated <input checked="" type="checkbox"/>
	Fidgety <input type="checkbox"/>	Regressed <input type="checkbox"/>	Dramatic <input type="checkbox"/>
3.) Attitude:	Cooperative <input checked="" type="checkbox"/>	Uncooperative <input type="checkbox"/>	Distant <input type="checkbox"/>
	Defiant <input checked="" type="checkbox"/>	Mute <input type="checkbox"/>	
4.) Mood:	Euthymic <input type="checkbox"/>	Elated <input type="checkbox"/>	Sullen <input checked="" type="checkbox"/>
	Anxious <input checked="" type="checkbox"/>	Frightened <input type="checkbox"/>	Dejected <input checked="" type="checkbox"/>
	Hostile <input type="checkbox"/>	Suspicious <input type="checkbox"/>	Guarded <input type="checkbox"/>
5.) Affect:	Constricted <input type="checkbox"/>	Labile <input checked="" type="checkbox"/>	Blunted <input type="checkbox"/>
6.) Content:	Regressive Themes <input type="checkbox"/>	OCB Themes <input type="checkbox"/>	Anxiety Themes <input type="checkbox"/>
	Negativistic Themes <input checked="" type="checkbox"/>	Psychotic Themes <input type="checkbox"/>	Rebellion <input checked="" type="checkbox"/>
	Depressed <input checked="" type="checkbox"/>		
7.) Process:	Intact <input checked="" type="checkbox"/>	Derailment <input type="checkbox"/>	Disconnected <input type="checkbox"/>
	Flighty <input type="checkbox"/>	Diminished <input type="checkbox"/>	Psychotic <input type="checkbox"/>
	Organic <input type="checkbox"/>	Absent <input type="checkbox"/>	Impaired <input type="checkbox"/>
8.) Perception:	Hallucinations <input type="checkbox"/>	Delusions <input type="checkbox"/>	Intact <input checked="" type="checkbox"/>
9.) Cognitive Capacity:			Intact <input checked="" type="checkbox"/> Not Intact <input type="checkbox"/>
	Calculation		<input type="checkbox"/>
	Concentration		<input checked="" type="checkbox"/>
	Abstraction		<input type="checkbox"/>
	Fund of Knowledge		<input type="checkbox"/>
10.) Orientation:	Time		<input type="checkbox"/>
	Place		<input type="checkbox"/>
	Person		<input type="checkbox"/>
11.) Memory:	Recent		<input type="checkbox"/>
	Immediate		<input type="checkbox"/>
	Remote		<input type="checkbox"/>
12.) Insight:			<input type="checkbox"/>
13.) Judgment:			<input type="checkbox"/>
14.) Lethality:	Ideation <input type="checkbox"/>	Intent <input type="checkbox"/>	Plan <input type="checkbox"/>
			Denied <input checked="" type="checkbox"/> current <input checked="" type="checkbox"/> past hx

DIAGNOSIS:

AXIS I: Major Depression, single

AXIS II: Dependent

AXIS III: none

AXIS IV: STRESSORS Parent-child conflict

AXIS V: GAF PRESENT 40 PAST YR BEST 70

TREATMENT PLAN:

Biological:

bring copy I.P.O. 2 Dec

Psychological:

Family Therapy
Parents - child esp mother - daughter
family

Social:

needs structure of discipline

Send copy of assessment to: (with face letter thanking for kind referral)

YES NO

PROGRESS NOTES FOR EXTENDED INDIVIDUAL/GROUP
MEDICATION MANAGEMENT SESSION

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PATIENT'S NAME [REDACTED]

DATE: 8/20/98

- S: 1. How have you been since the last time? Nothing changed.
and Mom still bites my head off all the time
and dad still expects me to be like him
2. Have you changed your medicines Yes No (Explain below)
3. Are you having side effects Yes No (Explain below)
4. Are you having unusual thoughts, change in temper, legal or emotional difficulties, suicidal or homicidal ideas? Yes No (Explain below)
5. Please explain any answers (use back of sheet for more space)

Parents need firmly therapy & how to get
firm fair rules

DOCTOR'S SECTION:

I. MSE

Mood: E D M

Affect: A INA

Content: OCD A D P Rel

M Ch

Cog: In poor Not In

L: Y N

Change in I/J: Y N

II. PE/LABS: WNL NWNL

III. A:

IV. P:

V. F/U:

altercation (argument) and
fight
at school

? classroom
with
hurt knuckles
by hitting a
wall

told me she's
having suicidal
thoughts

has now been hitting
her mother who has
cerebral palsy
youngest sister
needs much attention
+ pt has no
tolerance.

"you've had no idea
what's been wrong
with me"

(said crying to her
parents"

Hx of prior suicide attempt
"I never told my parents"
(cut her wrist,

Probable Hx of sexual abuse (not yet fully developed)
Not by family.

Marital problem
between parents

Mother/DAD also may need anti-dysent
been on Prozac 20mg for 2 wks condition is poor

Imp.
Maj. Depress
Plan.
Adapt
Dr. [REDACTED]

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PROGRESS NOTES FOR EXTENDED INDIVIDUAL/GROUP
MEDICATION MANAGEMENT SESSION

PATIENT'S NAME [REDACTED]

DATE: 9/2/98

- S: 1. How have you been since the last time? Pretty good. Were getting along better now
2. Have you changed your medicines Yes No (Explain below)
3. Are you having side effects Yes No (Explain below)
4. Are you having unusual thoughts, change in temper, legal or emotional difficulties, suicidal or homicidal ideas? Yes No (Explain below)
5. Please explain any answers (use back of sheet for more space)

Depicote

DOCTOR'S SECTION:

I. MSE Mood: E D M Affect: A INA
Content: OCD A D P Rel
M Ch
Cog: In Not In L Y N
Change in I/J Y N

MR PE/LABS: WNB NWN
EM: Depicote 50mg

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PROGRESS NOTES FOR EXTENDED INDIVIDUAL/GROUP
MEDICATION MANAGEMENT SESSION

PATIENT'S NAME

[REDACTED]

DATE:

9/8/98

- S: 1. How have you been since the last time? Good, [REDACTED]
Bought w/ dad
2. Have you changed your medicines ___ Yes No (Explain below)
3. Are you having side effects Yes No (Explain below)
4. Are you having unusual thoughts, change in temper, legal or emotional difficulties, suicidal or homicidal ideas? ___ Yes No (Explain below)
5. Please explain any answers (use back of sheet for more space)
- Really bad. Don't know if caused by meds though.

DOCTOR'S SECTION:

I. MSE Mood: E ___ D M ___ Affect: A ___ INA ___
Content: OCD ___ A D P ___ Rel ___
M ___ Ch ___
Cog: In Not In ___ L: Y ___ N
Change in I/J: Y ___ N

II. PE/LABS: WNL NWNL ___

III. A:

Depressive level

discuss friendships w/ [REDACTED]

IV. P:

V. F/U:

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PROGRESS NOTES FOR EXTENDED INDIVIDUAL/GROUP
MEDICATION MANAGEMENT SESSION

CC # EDR-2789

PATIENT'S NAME

CFSAN Project # 13072

DATE:

9/1/98

11/23/98 98

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- S: 1. How have you been since the last time? Things have gotten worse. Need to be (you) alone for a couple of minutes. I am requesting to be taken out.
2. Have you changed your medicines ___ Yes ___ No (Explain below) No
3. Are you having side effects ___ Yes ___ No (Explain below) No
4. Are you having unusual thoughts, change in temper, legal or emotional difficulties, suicidal or homicidal ideas? ___ Yes ___ No (Explain below)
5. Please explain any answers (use back of sheet for more space)

DOCTOR'S SECTION:

I. MSE

Mood: E ___ D ___ M ___

Affect: A ___ INA ___

Content: OCD ___ A ___ D ___ P ___ Rel ___

M ___ Ch ___

Cog: In ___ Not In ___

L: Y ___ N ___

Change in I/J: Y ___ N ___

II. PE/LABS:

WNL ___ NWNL ___

III. A:

Sent to Emergency [redacted] E not [redacted]
Father admitted to hitting daughter more

IV. P:

Then once confirmed by mother
in this office in front of both
daughter & pt's father

V. F/U:

+ confirmed pt. Father's sister
[redacted] told [redacted] provide Emergency
Shelter for daughter sent

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