QUIET GROWTH BEHAVIORAL HEALTH

Quiet Growth Behavioral Health Main Campus
123 Mainstreet
Phoenix, AZ, 85355
(405) 578-5031

INTAKE & BEHAVIORAL HEALTH ASSESSMENT

Assessment Date: Jun 29, 2026

PATIENT DEMOGRAPHICS

Basic patient identification information

Patient Identity

First Name
George

Last Name
Howard

Date of Birth
Jul 18, 2001

Gender
Male

Age
24

Contact Information

Phone Number
(602) 555-0125

Home Address
3663 N Scottsdale Rd
Scottsdale, AZ, 85282

Additional Information

Preferred Language
English

SSN (Last 4 Digits)
***-**-1234

Marital Status
Married

GUARDIAN & EMERGENCY CONTACTS

Guardian information and emergency contact details

Legal Guardian

Does patient have a legal guardian?

No

Primary Emergency Contact

Emergency Contact John Johnson (spouse) (602) 555-0124

Advance Directives

DNR (Do Not Resuscitate) Order?

No

Advance Directive / Living Will?

No

Healthcare Power of Attorney (POA)?

No

INSURANCE & COVERAGE

Health insurance and coverage information

Primary Insurance

Insurance Type	Insurance Company / MCO / Plan Name
Medicaid/AHCCCS	AHCCCS
Member ID / Policy Number	**Who holds this insurance policy?**
AC123456789	Self (Patient)

Secondary Insurance (Optional)

Does patient have secondary insurance coverage?

No

ADMISSION INFORMATION

Admission details, referral source, primary care physician, evaluation details, and room assignment

Admission Details

Admission Type	Admission Date	
Voluntary	Jun 30, 2026	
Floor	**Room Number**	**Bed Number**
1	102	Bed 1

Referral Information

Referral Source	Referral Contact Name
Physician/Provider	Dr. Michael Chen, MD
Referral Date	

Jan 7, 2026

Evaluation Details

Date of Evaluation Jan 7, 2026	**Evaluator Name** Dr. Michael Chen, MD
Evaluator Credentials 25896	

Primary Care Physician

BEHAVIORAL HEALTH SYMPTOMS

Chief complaint and presenting symptoms

Chief Complaint	"I've been having panic attacks and can't sleep. I feel like I'm losing control."
Patient's Goals for Treatment	dfd
History of Present Illness	George is a 40-year-old female with a documented history of generalized anxiety disorder and major depressive disorder who presents with an acute exacerbation of anxiety symptoms. She reports experiencing daily panic attacks over the past two weeks, characterized by palpitations, shortness of breath, sweating, and fear of dying. These symptoms have been accompanied by significant sleep disturbance, with only 2 to 3 hours of sleep per night, decreased appetite, and pervasive worry about financial stability following a recent job loss. She describes feeling a loss of control and endorses passive suicidal ideation without active plan or intent. Her mood is anxious and dysthymic, and her affect is congruently anxious. Insight remains good, though judgment is assessed as fair. Residential treatment is being sought due to the severity and acuity of her symptoms, including frequent panic attacks, significant functional impairment related to sleep deprivation and anxiety, and the presence of passive suicidal ideation. The recent job loss and associated financial stressors have precipitated this exacerbation, and the patient has discontinued her prescribed sertraline medication due to concerns about side effects, contributing to symptom escalation. The moderate risk level and the need for close monitoring, medication management, and intensive therapeutic interventions support the recommendation for inpatient care. The treatment plan includes resumption of sertraline, consideration of short-term anxiolytics, individual cognitive behavioral therapy focusing on anxiety management, group therapy, family education, and structured milieu activities. Relevant clinical history includes a prior diagnosis of alcohol use disorder, with the last reported use six months ago, and current abstinence. She remains engaged with Alcoholics Anonymous, which is incorporated into her discharge planning. There is no indication of recent substance use contributing to the current presentation. Compared to

	previous assessments, this episode represents a notable worsening in symptom severity and functional impairment, likely related to psychosocial stressors and medication noncompliance. The patient identifies her spouse and children as protective factors, which will be integrated into her treatment and discharge planning.
Precipitating Events	Job loss approximately 2 weeks ago.

Clinical Acuity

Clinical Acuity Level

Level 3 - Emergent

Acuity Justification	Risk level: MODERATE; Passive suicidal ideation; History of suicide attempt(s)

Symptom Timeline

When did symptoms begin? Weeks ago	**Overall Symptom Severity** Severe
Course of Symptoms Worsening	

Standardized Screening Scores

Mood Symptoms

☐ Depression / Depressed Mood	☐ Hopelessness / Worthlessness
☐ Mania / Elevated Mood	☐ Irritability / Anger

Anxiety Symptoms

☐ Anxiety / Excessive Worry	☐ Panic Attacks
☐ Obsessive Thoughts	☐ Compulsive Behaviors
☐ Trauma-related Symptoms	

Psychotic Symptoms

☐ Hallucinations (auditory/visual)	☐ Delusions
☐ Paranoia / Suspiciousness	☐ Disorganized Thinking

Cognitive & Behavioral Symptoms

☐ Difficulty Concentrating	☐ Sleep Disturbance
☐ Appetite Changes	☐ Agitation / Restlessness
☐ Dissociation	

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Substance-Related Symptoms

☐ Substance Cravings	☐ Withdrawal Symptoms

Symptom Triggers & Patterns

Known Symptom Triggers Stress related to job loss and financial instability.

Functional Impairment

☐ Work / School	☐ Relationships / Social	☐ Self-Care / ADLs

RISK ASSESSMENT

Suicide, self-harm, and danger to others assessment

Suicide Risk Assessment

History of Suicide Attempts
One attempt

Suicide Attempts Details One previous attempt 08/2023

Most Recent Attempt
Aug 1, 2023

Current Suicidal Ideation
Active (no plan)

Suicidal Ideation Details Passive thoughts, no plan or intent

Safety Interventions

Safety Plan in Place? No	**Lethal Means Restricted?** Yes

DTS (Danger to Self) Risk Factors

☑ Previous suicide attempts	☐ Family history of suicide
☐ Recent significant loss	☐ Active substance use
☐ Access to lethal means	☐ Hopelessness
☐ Impulsivity	☐ Social isolation
☐ Chronic pain/illness	☐ Serious mental illness
☐ Command hallucinations	☐ Recent psychiatric discharge (<30 days)

Protective Factors

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☑ Family/social support	☐ Engaged in treatment
☐ Future-oriented thinking	☑ Religious/spiritual beliefs
☐ Responsibility for children	☐ Positive coping skills
☐ Employment/purpose	☐ Fear of death/pain

Non-Suicidal Self-Injury (NSSI)

History of Self-Harm

None

Danger to Others (DTO) Assessment

Homicidal Ideation

None

History of Violence/Aggression

None

Does Duty to Warn Apply?

No

DTO Risk Factors

☐ History of violence	☐ Access to weapons
☐ Active psychosis	☐ Substance intoxication
☐ Treatment noncompliance	☐ Impulsivity/poor control

Elopement Risk (Residential)

Elopement/AWOL Risk

Low

Overall Risk Level

Current Overall Risk Level

Moderate

PSYCHIATRIC & SUBSTANCE TREATMENT HISTORY

Prior hospitalizations, residential treatment, outpatient care, diagnoses, and treatment response

Prior Mental Health Treatment

both

Previous Psychiatric Diagnoses Generalized Anxiety Disorder, Major Depressive Disorder

Response to Previous Treatment	Patient was compliant with sertraline until 1 week ago when stopped due to side effect concerns.

MEDICATIONS & ALLERGIES

Current psychotropic and other medications, compliance, and drug allergies

Psychotropic Medications

Currently taking psychotropic medications?

Yes

Psychotropic Medications	1. **Sertraline** · 100mg · Tablet · Qty: 5 · Dose: 1 · Route: By Mouth · Freq: Daily · Rx: MD John

Medication Compliance History

Compliant

Other Medications

Currently taking other (non-psychiatric) medications?

No

Allergies & Adverse Reactions

Known Drug Allergies?

No

MEDICAL HISTORY

Physical health conditions, neurological history, and family history

Does the patient have any chronic medical conditions?

Yes

Chronic Medical Conditions	Hypertension, Diabetes Type 2, Thyroid Disorder

Any past surgeries or medical hospitalizations?

No

History of Head Injuries/TBI

None

History of Seizures

No

Currently Pregnant (if applicable)

N/A

Significant family medical history?

Yes

Family Medical History	Mother: Diabetes, Hypertension; Father: Heart disease; Sister: None

Significant family psychiatric history?

Yes

Family Psychiatric History	Mother: Depression, Anxiety; Father: None reported; Sister: Bipolar disorder

SOCIAL HISTORY

Living situation, relationships, support system, and trauma history

Marital Status

Married

Current Living Situation

Spouse

Is Housing Stable?

Yes

Number of Dependents/Children

2 (Ages 12, 14)

Does the patient identify a support system?

Yes

Support System	Spouse, mother, AA sponsor

Abuse/Trauma History

History of Physical Abuse

None

History of Sexual Abuse

None

History of Emotional/Verbal Abuse

None

History of Neglect

Childhood

Trauma/Abuse Details (if patient wishes to share)	Reports emotional neglect in childhood due to father's drinking.

Current Domestic Violence Concerns

No

EDUCATION HISTORY

Educational background, special education, and learning needs

Highest Level of Education

Bachelor

Education Details Bachelor's Degree, Business

Currently Enrolled in School?

No

History of Special Ed Services?

No

EMPLOYMENT HISTORY

Current employment status, work history, and financial situation

Current Employment Status

Seeking

Receiving Disability Benefits?

No

LEGAL/CRIMINAL HISTORY

Current legal involvement, criminal history, and court-ordered treatment

Legal/Criminal Justice Involvement

None

On Probation/Parole

No

Court-Ordered Evaluation

No

Court-Ordered Treatment

No

SUBSTANCE ABUSE HISTORY

Substance use history, withdrawal, and treatment

History of Substance Use

Past Only

Substances Used

1. **Alcohol** · In Recovery · Route: Oral · Freq: Daily · Last: 2025-07-01 · *Heavy drinking 2019-2024 (1-2 bottles wine daily); last drink 6 months ago; previously attended AA meetings, completed outpatient treatment at Terros Health 2024; currently maintains sobriety with sponsor support*

Primary Substance of Choice

Alcohol

History of IV Drug Use

No

Withdrawal & Treatment History

Prior Substance Treatment History Previously attended AA meetings, completed outpatient treatment at Terros Health 2024

ACTIVITIES OF DAILY LIVING (ADLS)

Functional assessment of self-care, daily living skills, and psychosocial functioning

Overall Functional Status

Overall Functional Level

Fully Independent

Basic Self-Care (Personal ADLs)

Core activities: bathing, grooming, dressing, eating, toileting, mobility

Bathing/Hygiene

Independent

Grooming

Independent

Dressing

Independent

Feeding/Eating

Independent

Toileting

Independent

Mobility/Ambulation

Independent

Transfers (bed/chair)

Independent

Instrumental Activities (IADLs)

Daily living skills: meal preparation, housekeeping, laundry, finances, medication management, transportation, communication

Meal Preparation

Independent

Housekeeping/Cleaning

Independent

Medication Management

Moderate Assist

Financial Management

Independent

Laundry

Minimal Assist

Shopping/Errands

Moderate Assist

Transportation

Dependent on others

Sleep & Daily Routine

Sleep Quality

Good/Restful

Describe a Typical Day	The patient typically begins the day with a morning run.

Strengths, Limitations & Coping

Patient Strengths & Abilities	George demonstrates good insight into their condition and has a logical thought process, which supports effective engagement in treatment. They have strong social support from their spouse, mother, and AA sponsor, as well as protective factors including family support, religious beliefs, and a history of recovery. Although recently discontinuing sertraline due to side effects, George was previously compliant with medication, indicating motivation and willingness to participate in treatment.
Patient Limitations & Barriers	George is experiencing significant functional impairments related to recurrent panic attacks and insomnia, which contribute to difficulties in maintaining concentration and emotional regulation. The heavy alcohol use over several years likely exacerbates these symptoms, impairing judgment and increasing risk, thereby affecting George's ability to perform daily self-care and sustain consistent employment. Social interactions, including those with the spouse, may also be strained due to the combined impact of anxiety symptoms and substance use.
Current Coping Skills	George currently relies on alcohol use as a maladaptive coping strategy, having engaged in heavy drinking over several years. However, protective factors such as family support, religious beliefs, and involvement with an AA sponsor indicate engagement in healthier coping mechanisms and a commitment to recovery. Treatment should focus on strengthening adaptive coping skills while addressing the recent discontinuation of sertraline and reducing reliance on substances for stress management.

MENTAL STATUS EXAMINATION

Clinical mental status assessment

General Appearance

Grooming/Hygiene

Well-groomed

Behavior & Demeanor

Cooperation

Cooperative

Psychomotor Activity

Psychomotor Activity

Normal

Speech

Rate

Normal

Mood & Affect

Mood (patient's words)

Anxious, dysthymic

Affect (observed)

Anxious

Thought Process & Content

Thought Process

Logical

Delusions

None

Perceptions

Auditory Hallucinations

None

Visual Hallucinations

None

Cognition

Attention/Concentration

Intact

Memory

Intact

Insight

Good

Judgment

Fair

Orientation (check all that apply)	• Person • Place • Time

MINI-MENTAL STATE EXAMINATION (MMSE)

Standardized cognitive screening assessment

Administer MMSE?

No

CLINICAL SUMMARY & DIAGNOSIS

Case formulation and diagnostic impressions

Diagnostic Impressions (ICD-10)

Primary Diagnosis (ICD-10)	F41.1 - Generalized Anxiety Disorder
Secondary Diagnosis	F32.1 - Major Depressive Disorder, Single Episode, Moderate severity, in partial remission
Tertiary Diagnosis	F10.21 - Alcohol Use Disorder, Severe, in sustained remission E11.9 - Type 2 Diabetes Mellitus, Without complications I10 - Essential Hypertension
Substance Use Diagnoses	F10.21 - Alcohol Use Disorder, Severe, in sustained remission
Medical Diagnoses	Hypertension, Diabetes Type 2, Thyroid Disorder
Clinical Summary / Case Formulation	George is a 40-year-old female with a history of generalized anxiety disorder and major depressive disorder who presents with an acute exacerbation of anxiety symptoms following a recent job loss approximately two weeks ago. She reports daily panic attacks characterized by palpitations, shortness of breath, sweating, and fear of dying. These symptoms are accompanied by significant sleep disturbance, with only 2-3 hours of sleep per night, decreased appetite, and persistent worry about financial stability. She has discontinued her prescribed sertraline 100mg daily one week ago due to concerns about side effects. Additionally, George endorses passive suicidal ideation without active intent or plan, identifying her children and spouse as protective factors. Her psychiatric history includes prior treatment with both pharmacotherapy and psychotherapy, with one previous psychiatric hospitalization. She has a history of alcohol use disorder with heavy drinking from 2019 to 2024, abstinent for the past six months, and maintains involvement with Alcoholics Anonymous, supported by her sponsor. Psychosocially, she lives with her spouse and has a supportive family network including her mother. She reports a history of emotional neglect in childhood related to

her father's alcohol use but denies physical or sexual abuse. Mental status examination reveals an anxious and dysthymic mood with anxious affect, logical thought processes, good insight, and fair judgment. Risk assessment indicates a moderate level of risk due to passive suicidal ideation and a history of a previous suicide attempt, balanced by strong protective factors including family support, religious beliefs, and commitment to treatment.

The clinical presentation is consistent with an acute exacerbation of generalized anxiety disorder, likely precipitated by recent psychosocial stressors, including job loss and financial insecurity. The discontinuation of sertraline may have contributed to symptom worsening. The patient's history of alcohol use disorder and childhood emotional neglect are important psychosocial factors that may influence her current vulnerability and treatment response. Given the severity of symptoms, risk factors, and functional impairment, inpatient level of care is recommended to provide close monitoring, medication management including resumption of sertraline and consideration of short-term anxiolytics, and intensive psychotherapy focusing on anxiety management and coping skills. Family involvement and structured milieu therapy are also integral to the treatment plan to support recovery and relapse prevention.

This presentation represents a significant clinical deterioration from previous stability while on medication, underscoring the importance of adherence to pharmacotherapy and comprehensive psychosocial support. The recommended treatment approach includes inpatient stabilization followed by a step-down to intensive outpatient programming and continued engagement with outpatient psychiatry and community support groups. The admitting clinician should review and supplement this summary with ongoing clinical findings and assessment data to guide individualized care planning.

Recommendations

Recommended Level of Care

Inpatient psychiatric

Treatment Recommendations

George is recommended for inpatient level of care to provide a structured and supportive environment for stabilization. Medication management should include resuming sertraline 100 mg daily for generalized anxiety disorder, with consideration of short-term use of hydroxyzine 25 mg three times daily as needed for anxiety symptoms. Close monitoring for medication efficacy and side effects is essential during inpatient stay. Therapeutic interventions should include individual cognitive behavioral therapy twice weekly focusing on anxiety management and coping skills, as well as participation in group therapy sessions such as anxiety management and trauma-informed care groups. Family involvement is important; a family education session should be conducted within 48 hours of admission to support understanding and engagement in treatment. Milieu therapy with structured daily activities and relaxation techniques should be incorporated to enhance coping and reduce anxiety. Discharge planning must ensure continuity of care with outpatient psychiatrist Dr. Rodriguez, with a follow-up appointment scheduled within one week of discharge. Referral to an intensive outpatient program (IOP) is recommended to support ongoing recovery, alongside continued

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	involvement in Alcoholics Anonymous (AA) if applicable. A crisis plan should be developed collaboratively to address potential acute episodes. Monitoring for withdrawal symptoms, biomedical concerns, emotional status, readiness for change, relapse risk, and environmental factors should guide ongoing treatment adjustments. The clinical team should review and supplement these recommendations based on George's evolving clinical presentation and needs.
Medication Recommendations	George should resume sertraline 100mg daily as previously prescribed for mood and anxiety symptoms. Consider adding hydroxyzine 25mg three times daily as needed for short-term anxiety management. No changes to other current medications are indicated at this time based on available data. Given the history of alcohol use, monitor closely for withdrawal symptoms and consider appropriate interventions if withdrawal occurs. A psychiatric medication evaluation is recommended to assess ongoing medication efficacy and tolerability. Regular monitoring of symptom response and side effects should be conducted, with follow-up arranged with the outpatient psychiatrist within one week of discharge.
Staffing/Safety Recommendations	George requires routine supervision with 15-minute checks due to moderate risk and active suicidal ideation. One-to-one observation is recommended during periods of increased risk or distress. Fall precautions and medical monitoring are necessary given hypertension, diabetes type 2, and thyroid disorder. Sharps and ligature precautions should be implemented to mitigate self-harm risk. Substance withdrawal monitoring protocols should be in place for alcohol use. Staff should include licensed nurses (RN) for medical oversight and behavioral health technicians (BHT) trained in suicide prevention and medical monitoring. The admitting clinician should review and adjust these recommendations as needed.
Referrals	None needed at this time — patient is receiving comprehensive behavioral health services in the residential program.

SIGNATURES

PATIENT SIGNATURE *

Patient acknowledgment of assessment participation (per R9-10-707.B).



GEORGE HOWARD *Jun 30, 2026 7:48 AM UTC-7*

✓ *Electronically signed*

BEHAVIORAL HEALTH PROFESSIONAL SIGNATURE *

Signature of the Behavioral Health Professional.



SOFIA BROOKS, LCSW *Jun 30, 2026 7:48 AM UTC-7*

✓ *Electronically signed*

ELECTRONIC SIGNATURE VERIFICATION

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