NR 546 Week 5 Case Study

Subjective	Objective
The client MK, is a 32-year-old, white female being seen for a psychiatric evaluation at an outpatient clinic. **Client's Chief Complaints:** "I just feel down and not myself." **History of Present Illness** MK reports increasing depressive symptoms describes feeling overwhelmed by a persistent sense of sadness, which has been present for the past six months. MK reports a loss of interest in activities she once enjoyed, such as spending time with friends and engaging in hobbies. She notes difficulty concentrating at work and experiencing fatigue. Additionally, MK mentions changes in her appetite, with a notable decrease in food intake leading to unintentional weight loss over the past few months. Her husband has also shared that he has noticed she is "not herself." MK also reports difficulty falling and staying asleep due to anxiety and restlessness, difficulty making decisions, and self-isolation. She has found it difficult to go to work some days due to the stress and worry she is experiencing. She denies any thoughts of self-harm or suicide but admits to feelings of hopelessness about her future. **Past psychiatric history:** Denies any history of previous psychiatric diagnoses or treatment for depression. However, she acknowledges a family history of depression, with her mother and maternal aunt both having been diagnosed and treated for the condition; this is the client's first contact with a mental health provider. **Past Medical History:** none	**Physical Examination:** Height: 5'6″, weight: 135 lb. General: Well-nourished female appears stated age **Mental status exam:** Appearance: Appropriate dress for age and situation, well nourished, poor eye contact, 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. Denies thoughts of suicide, self-harm, or passive death wish Perceptions: Denies experiencing any perceptual disturbances, such as auditory or visual hallucinations. No evidence of psychosis, not responding to internal stimuli. Memory: Recent and remote WNL Judgement/Insight: Insight is fair, Judgement is fair Attention and observed intellectual functioning: Attention intact for the purpose of assessment. Able to follow questioning. Fund of knowledge: Good general fund of knowledge and vocabulary Musculoskeletal: Normal gait