Hi Human, Sarah Jamieson current visit

Patient forms:
PHQ9:
Results 2

Reason for visit: Referred for mood.

History:
HPI:
History of Present Illness (HPI):

SJ, a 24-year-old female, presents to the clinic with concerns about mood changes, including persistent irritability and low energy, over the past two weeks. These symptoms began following a distinct eight-day episode approximately two weeks ago, which she describes as unusual and concerning. During this episode, she experienced significantly increased energy, impulsive behaviors, and a sense of being "out of control but good." She reports engaging in a shopping spree that maxed out her credit card, consuming five 6-ounce mixed drinks in one night at a nightclub, and formulating an ambitious business plan to "save people's souls," which she abandoned shortly after. She also notes that her speech was so rapid that her friends and family had difficulty keeping up with her, and they described her behavior as uncharacteristic and worrisome.

The patient describes severe difficulty sleeping during the episode, reporting that she slept no more than 2-3 hours per night, often staying awake to clean her house or think about her business plans. This insomnia was uncharacteristic for her, as she typically sleeps 7–8 hours per night without difficulty. Since the episode resolved, she states that her sleep patterns have returned to normal. However, she has experienced persistent irritability daily for the past two weeks, which she describes as moderate and without clear triggers. She also reports moderate fatigue that began after the episode, which she states improves somewhat with rest but is unrelated to physical exertion.

The patient denies any previous episodes of elevated energy, impulsivity, or mood disturbances resembling this recent episode. She recalls a depressive episode during college that lasted several months, during which she withdrew socially, experienced poor academic

performance, lost weight, and felt worthless. That episode resolved without treatment. Currently, she denies depressive symptoms such as hopelessness, worthlessness, or anhedonia but acknowledges feeling "a little down" intermittently since the recent episode. She denies anxiety or suicidal ideation.

She expresses concern about the impact of her behavior on her family, particularly her stepmother, who referred to her business plan as "delusional." While the patient does not perceive her ideas during the episode as delusional, she acknowledges that her behavior was unusual and troubling to those around her. She also notes that the shopping spree and subsequent financial burden have added stress to her current situation.

The patient denies hallucinations, paranoia, or thought disorganization outside of the behaviors associated with the recent episode. She also denies memory problems, confusion, or impaired judgment at baseline but acknowledges poor judgment during the episode, particularly with excessive spending and drinking. She reports no significant changes in appetite, weight, or concentration. She denies nausea, vomiting, chest pain, or other somatic complaints.

She has no prior psychiatric history or treatment but is seeking evaluation today to understand better and address her current symptoms and prevent future episodes. Her family has expressed concern about her behavior and mood, which further motivated her to seek care.

ROS:
General:

The patient reports moderate fatigue following an eight-day episode marked by significantly increased energy and a reduced need for sleep. During this episode, she estimates she slept only 2–3 hours per night. This fatigue, which she describes as moderate in severity, has persisted for the past two weeks but shows slight improvement with rest. She denies weight changes, fever, chills, night sweats, or generalized weakness. The patient describes her overall health as "pretty good" and denies any recent illnesses.

HEENT/Neck:

Head: Denies headaches, dizziness, or head trauma.
Eyes: Reports being near-sighted and regularly wearing glasses or contacts. Denies vision changes or new problems with her eyes.
Ears: Denies hearing changes, tinnitus, or ear pain.
Nose: Denies nasal congestion, discharge, or bleeding.
Throat: Denies sore throat, difficulty swallowing, or voice changes.
Neck: Denies pain, stiffness, swelling, or lumps.

Cardiovascular:

Cardiovascular: Denies chest pain, palpitations, orthopnea, paroxysmal nocturnal dyspnea (PND), or syncope. Reports no history of high blood pressure or other cardiovascular conditions. Denies swelling (edema) or any changes in exercise tolerance.

Respiratory:

Denies shortness of breath, cough, wheezing, hemoptysis, or chest pain associated with breathing. Denies any history of respiratory infections or recent illnesses. Reports no exposure to secondhand smoke and denies a history of smoking or vaping.

Gastrointestinal:

Denies changes in appetite, nausea, vomiting, abdominal pain, bloating, or heartburn. Denies constipation, diarrhea, or changes in bowel habits. Denies blood in the stool or difficulty swallowing.

Genitourinary:

Denies dysuria, vaginal discharge, or discomfort. Reports regular menstrual cycles and states they are "regular." Denies problems with periods. Denies being pregnant. Reports using oral contraceptive pills as birth control, stating she took her medication this morning. Denies recent changes, missed doses, or stopping birth control pills.

Musculoskeletal/Osteopathic/Structural:

Denies joint pain, muscle pain, stiffness, swelling, or cramping. Denies weakness, deformities, or limitations in range of motion. Denies difficulty walking, instability, or balance issues. Denies back pain or recent injuries.