

Office Visit - Sep 29, 2025

with Cheryl Carmin, PhD at OSU Behavioral Health



Notes from Care Team



Progress Notes by Cheryl Carmin, PhD at 9/29/2025 12:00 PM

****You are about to read part of the chart with sensitive personal information. This part of the chart should not be discussed without provider and patient approval.****

OUTPATIENT BEHAVIORAL HEALTH INTAKE ASSESSMENT

Start Time: 12:00 **Stop Time:** 1:00

Total Time: 60 min of assessment time

Informant(s): patient

Referral Source: outpatient provider - cardiac rehab

HISTORY OF PRESENT ILLNESS: William Hodges is a 57 y.o., divorced, Caucasian male who was referred by Michael Wesley Milks, MD/ Self, Self for assessment and treatment of anxiety and depression.

Has seen therapists in the past.

Fa left when he was 2yo. Met him when he was around 10yo then his father died when he was 13yo. Misses having had a father figure. Mo was financially challenged. Has 2 sisters - 10 yrs older, one out of the house and the 2nd shortly thereafter in their teens. Mom was a drinker - "weekend alcoholic." Described himself as "free spirited." Grew up in Roanoke, VA and moved to Dayton. After Fa left, mom went back to Roanoke. There was abuse between his mom and her SO. He \sStarted working when he was 8yo and spent a good deal of time running the streets. There was a neighbor that was like a second family.

Hx of TBI - 5 - 6yo, he fell down iced-over steps. At 12yo, kid pushed him off the top of a slide and he hit his head on a metal bar, he was bleeding, doesn't remember if they went to the hospital. In 2010 was robbed on the job and had a head injury and had a 3-week memory gap, craniotomy and now has a plate. Was in the hospital about 3 mos. Has a limited sense of smell which is the only residual effect other than memory gaps.

Mo has hx of CABG. He had a CABG in 2012, PCI x4 (2 here), thinks 2 MI,

Carries a lot of stress. High anxiety but doesn't recognize that he's anxious. Worries about finances, failure/loss/trauma (What would life be like if he had a Fa figure, failed at being a good Fa to his daughter, hard to not have a mom who was more involved, had a business that took over his life and cost him his wife, daughter, etc. Wanted to go into the military but at 12yo he threw a snowball at a car and he couldn't enlist in the Air Force. His daughter also did ROTC - she got pregnant and moved to Australia. They are estranged -- hasn't seen her in 15 yrs, hasn't spoken to her in 13 yrs.

His friends have pushed him to go into therapy. Daughter posted on Tik Tok. Asked his ex-wife about it. He spanked his daughter at least x1. Had tried all sorts of other interventions first. Had left a mark. She was removed from the house x3 yrs. His wife supported him. Question re whether his

discipline got out of hand a couple of times. Came back home at 12-13yo. They did things together and things seemed good. Daughter came to visit when he had the craniotomy. They had a conversation 2 yrs later and was told he said that he was going to kidnap his granddaughter when she was 3 yo. None of this made sense to him.

Depression, anxiety, anger mgmt, personality

Depressed - has no desire for life but not suicidal. Not hugely motivated. No interest in dating. Wants to sleep a lot.

Has bariatric appt

BEHAVIORAL HEALTH ROS:

Depression: sad mood, anhedonia, increased sleep, and low energy

Mania: no

Anxiety: generalized anxiety

Psychosis: no

Motor: no

Other: all other ROS negative

PATIENT-REPORTED OUTCOMES:

Interpretation of total score: 0–4: minimal; 5–9: mild; 10–14: moderate; 15–21: severe

(if applicable, report for patients with non-zero response should be forwarded to EPICENTER team)

Work and Social Adjustment Scale (WSAS)

Scores range from 0 – 40. Scores >20 reflect moderately severe or worse psychopathology; Scores 10-20 reflect significant functional impairment with less severe clinical symptomatology.

Nutrition/Eating Disorder Screen:

1. Did patient uncontrollably eat a large amount of food, (more than what others would eat in the same time period) 2 or more times a week over **the last 3 months**? No
 2. Over the last 3 months, has patient experienced distress when she/he eats, making it difficult to consume a needed amount of food to maintain healthy or expected weight? No
 - *If Yes, was there:*
 - physical distress such as swallowing, stomach, bowel or other body complications? No
 - dental problems such as gum disease or dry mouth? No
 - distress when eating with others, or in social situations? No
 - emotional distress such as fear, panic or nervous that you ate too much or specific foods? No
 - inability to concentrate and do work or activities? No
 3. Does patient purge to counter what he/she has eaten because he/she feels too fat? No
- Other nutritional problems may include a weight loss or weight gain of 10 pounds or more in the past three months, a change in appetite, dental problems, noncompliance with a special diet, and food allergies.*

If the answer is yes to any of the above problems, refer patient for a nutritional assessment.

Child/Adolescent Psychiatric History and Developmental ROS:

ADHD: no

Conduct problems: no

Autism spectrum: no

Developmental history: not assessed

SUICIDE AND VIOLENCE RISK FACTOR ASSESSMENT:

ED-SAFE:

Over the past 2 weeks, have you felt down, depressed, or hopeless? yes

Over the past 2 weeks, have you had thoughts of killing yourself? no

Suicide Risk & Safety:

Suicidal ideation (current): patient admits to thoughts but denies active plan or intent

Suicidal actions (current): none

Past suicide attempts:

Have you ever attempted to kill yourself? no

If yes, when did this last happen? N/A

Nonsuicidal self injury (current): No

Past self-injurious behavior: No

Demographic and social risk factors: male, caucasian, and single

Historical risk factors: none

Medical risk factors: physical illness

Psychiatric risk factors: none

Psychological risk factors: Lack of social support

Access to guns or other weapons: No

Protective factors: religion or cultural beliefs; willingness to contract for safety

Violent Ideations & Plans

Violent ideation (current): no

Past violent behavior/ideation: no

Agitation (current): no

Specific target identified: no

BEHAVIORAL HEALTH HISTORY:

Family psychiatric/substance use history: Mother - EtOH

Family suicide attempts/completions:

Previous psychiatric diagnoses: See above

Psychiatrist (current): no

Case manager (current): no

Therapist/Counselor (current): no

TMS/ECT: no

Psychiatric Hospitalizations: N/A

Dates	Hospital	Indication	Duration

PHP/IOP (start with current, if any): N/A

Dates	Facility	Indication	Response

Psychotherapy (start with current, if any): N/A

Dates	Type (e.g, CBT, dynamic, supportive)	Indication	Response

	Seen multiple therapists over the years		

Past psychiatric medications (current meds below): N/A

Dates	Name	Dose (frequency)	Indication	Response

SUBSTANCE USE:

AUDIT-C score (sum 3 items below): 0

How often does the patient have a drink containing alcohol? (0) never

How many standard drinks containing alcohol does the patient have on a typical day? (0) 1 or 2

How often does the patient have 6 or more drinks on one occasion? (0) never

Quantity of current drug use: none

Perceived substance abuse problem (current): no

History of dependence/addiction: no

Consequences of dependence/addiction:

Mental/emotional: no

Behavioral (e.g., work, school, financial):no

Legal: no

Social (e.g., divorce, relationships): no

Medical/physical: no

If the answer is yes to any of the above problems, elaborate on consequences above.

Substance abuse treatment history: N/A

Dates	Level of care (e.g., IP, PHP, AA, etc.)	Response/Length of sobriety

PAST MEDICAL HISTORY:

Patient has been informed of the importance of maintaining updated medication information/medical history. Yes

If No, explain:

Pt has a past medical history of CAD (coronary artery disease), Essential hypertension, benign, Hyperlipidemia, and TBI (traumatic brain injury).

Pt has a past surgical history that includes coronary artery bypass graft (2012); ptca; coronary stent placement (2019); coronary angioplasty (N/A, 05/13/2024); coronary stent placement (N/A, 05/13/2024); coronary stent placement (N/A, 04/14/2025); and craniotomy (2010).

Pt has no known allergies.

Pt has a current medication list which includes the following prescription(s): aspirin, atorvastatin, clopidogrel, repatha, isosorbide mononitrate, lisinopril, metoprolol, and nitroglycerin.

PHYSICAL EXAM TRIGGERS:

Has it been more than a year since the patient's last physical? No

Do the patient, guardian, or clinician have concerns about the patient's health? No

Has there been any worsening of a chronic health condition since the patient was last seen by a healthcare provider? No

If the answer is yes to any of the above questions, refer pt to PCP for follow-up. If pt is in need of PCP, place referral to establish care.

FALL RISK ASSESSMENT:

If the answer is YES to any ONE of the following, pt is a HIGH risk for falls. Offer fall risk teaching handout and direct pt to their PCP or refer to appropriate consultative service.

History of fall in the past three months: No

Altered gait/mobility: No

Altered mental status: No

If the answer to all three of the above is NO, complete this secondary screen. If the answer is YES to TWO or more of the following, pt is a at a HIGH risk for falls. Offer fall risk teaching handout and direct pt to their PCP or refer to appropriate consultative service.

High-risk medication use: No

Altered elimination: No

Attached to equipment/IV pole: No

Sensory/communication deficits: No

Secondary diagnosis/physiological risk: No

MENTAL STATUS EXAMINATION:

Appearance: appropriate

Interview behavior: cooperative

Eye contact: good

Attention: normal

Orientation: time, place, and person

Mood: anxious

Affect: appropriate

Speech: normal

Thought process: disorganized; circumloquacious

Cognitive impairment: stated he has memory issues from TBIs

Delusions: none

Hallucination: none

Motor Activity: normal

Insight: good

Judgment: good

Impulse control: intact

Sleep: increased more than normal

Appetite: no change from normal

Energy level: fair

Pain: No; *if present*, quality, location, duration:

CURRENT Pain: 0 (No Pain)

Pain interference: 0 (Not At All)

SOCIAL HISTORY:

Pediatric History

Patient Parents

- BAILEY,PATTY (Mother)

- Not on file

Social History Narrative

Lives in Dayton, OH. Daughter live in Australia.

Pt's family history includes Coronary Artery Disease in his sister; Coronary Artery Disease (age of onset: 38) in his mother; Kidney Disease in his sister; Lipid Disorder in his sister.

Childhood: chaotic - Fa left when he was young, mother moved and was drinking

Current living situation: Currently lives with

Relationships/support: friends

Education: degree; Employed as driver for Dominos

Trauma/abuse/DV history: head injury

Legal issues/history: no

Strengths: perseverence

Religious considerations: faith is important

Cultural/ethnic considerations: none noted

Language spoken at home: English

LEARNING CONSIDERATIONS:

Barriers to learning: (e.g., sensory impairments, reading difficulties, language)

Patient: No

Caregiver/family: NA

Readiness to learn: (e.g., eager, acceptance, non-acceptance, or refused)

Patient: accepting

Caregiver/family: N/A

Preferred learning method(s): (e.g., visual, auditory, written, demonstration/modeling)

Patient: not assessed

Caregiver/family: N/A

CLINICAL IMPRESSION: William Hodges is a 57 y.o., divorced, Caucasian male who presents with anxiety and depression. Evidence supports a diagnosis of generalized anxiety and depression however, further assessment of pt's sx profile is needed. Pt provides excessive detail in order to explain his experiences leaving little time for a diagnostic impression Pt would benefit from cognitive behavior therapy. The initial focus of treatment would be anxiety mgmt, with a goal of symptom reduction. Formal treatment plan to follow in three months.

DIAGNOSIS:

No diagnosis found.

RECOMMENDATIONS/PLAN:

1. Level of care: Outpatient Psychotherapy
2. Coordination of care: Collaboration and communication with referring provider
3. Further evaluations/referrals placed: None
4. Pt encouraged to communicate via MyChart or call the clinic with worsening symptoms, side effects, questions, or concerns. Reviewed emergency protocol (call 911 or go to ED) and safety plan as needed.

Patient has been informed of the limits of confidentiality: ☒ yes ☐ no

If No, explain:

Patient was informed of the no show/late cancellation policy. Patients will be dismissed from the practice if they fail to keep three (3) appointments within a rolling 12-month period. This policy includes no shows and cancellations with less than 24 hours notice). ☒ yes ☐ no

Discussed automatic release of notes via MyChart with patient, including potential for proxy access: ☒ **yes** ☐ **no**

Pt expressed understanding and consented to receiving progress notes via MyChart.

Pt understands that they are welcome to request a copy of their medical records, including these notes, at any time.

Patient and/or patient's family (with consent for adult patient) has participated in developing treatment plan: ☒ **yes** ☐ **no**

If No, explain: