

Office Visit - Oct 28, 2025

with Hunter Sully, PhD at Behavioral Health Philip Heit Center

 Notes from Care Team ▼

Progress Notes by Hunter Sully, PhD at 10/28/2025 2:00 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 PROGRESS NOTE

Start Time: 2:00 p.m. **Stop Time:** 2:59 p.m.
Total Time: 59 min of psychotherapy time

Patient Present at Session yes
If no, state reason: N/A
If others present, please list name(s) and relationship(s) to client: N/A

Present Complaints & Interim History:
William Hodges is a 57 y.o., divorced, Caucasian male who was self-referred by for assessment and treatment of depression and anxiety. Client reported experiencing symptoms of depression and anxiety related to his trauma history and interpersonal challenges. Client noted that he has experienced a number of traumatic experiences in his life, including losing custody of his daughter, experiencing the failure of his business, divorcing his ex-wife, his mother dying, being accused of domestic violence, and losing a close friend to substance use. Client reported that he has experienced difficult in interpersonal relationships throughout his life, noting that he frequently feels misunderstood by most people in his life. Client reported that currently, he does not have any friends that live close to him, which contributes to feelings of loneliness and isolation.

Patient-Reported Outcomes:
PHQ-9: 13 (Moderate Depression)
GAD-7: 8 (Mild Anxiety)
WSAS: not completed today

Mental Status Examination:
Appearance: appropriate
Attention: normal
Interview behavior: cooperative
Orientation: time, place, and person
Mood: "okay"; anxious
Affect: appropriate
Thought process: circumstantial
Insight: fair
Judgment: fair
Impulse control: intact

Sleep: poor with DIMS (difficulty initiating & maintaining sleep) and wants to sleep all the time
Appetite: no change from normal, eats 2-3 meals a day.
Energy level: fair

Pain: 0 (No Pain)

Suicidality & Safety (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

Have you ever attempted to kill yourself? no

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

Suicidal ideation: denied by patient

Homicidal ideation: denied by patient

Does the patient have access to weapons, particularly firearms, in the home? no

Protective factors: religious beliefs, social support, willingness to contract safety

Are there relevant changes in health status, medications, medication-related side effects/symptoms? no;

Psychotherapeutic, Psychoeducational or Supportive Interventions: Session focused on establishing care and developing therapeutic alliance. Client and therapist discussed onset of symptoms, how they have impacted the client in the various areas of his life, as well as how the symptoms of depression and anxiety are being maintained presently. Supportive and interpersonal psychotherapy was provided.

Follow Up Plan: Continue individual therapy. RTC in 1 week. Next session will focus on the short-term goal of developing therapeutic rapport and helping client develop coping strategies to manage distress. The long-term goal of improving mental health symptoms and overall functioning remains appropriate and patient is making progress toward this goal. Pt was in agreement with plan.