

Telemedicine - Dec 17, 2025

with Hunter Sully, PhD at Behavioral Health Philip Heit Center



Notes from Care Team



Progress Notes by Hunter Sully, PhD at 12/17/2025 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:** 3:01 p.m.
Total Time: 61 min of psychotherapy time

Telepsych session? Yes. This telehealth visit is being conducted by real-time video. During the scheduling process, this patient has verbally consented to the submission of Telehealth visits and the patient is aware of the risks, benefits, and possible coinsurance/copay costs.

Telehealth Patient Location

Patient's physical location at time of visit: Home

Pt stated they were in a private space and verified safety. I participated from my office in Columbus, OH. In the event of technical problems, we agreed to reconnect to video, and if unsuccessful, therapist would contact client via phone. Pt's identified emergency contact is Patty Bailey. In the event of a crisis, we agreed to the following safety plan: call 911 or go to the local ER. The closest ED to the patient's location is Miami Valley Hospital North Campus.

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.

Client presented to therapy with symptoms of anxiety and depression related to a recent conversation with his daughter and his interpersonal style. Client noted that his daughter recently inquired about whether the client meets criteria for ADHD. Client explained that he has a family history of ADHD (daughter and sister). Client expressed ambivalence about the value of a diagnosis of ADHD. Client described a history of multiple head injuries, including several TBIs and a craniotomy, with some short-term memory impairment noted prior to the injuries and minor issues

with certain smells but no other significant symptoms reported. Client reported continuing to experience challenges with anger management, but demonstrated recent success in managing anger in interactions with his daughter and a friend.

Patient-Reported Outcomes:

PHQ-9 Total Score (Interpretation of Total Score 1-4 = Minimal depression; 5-9 = Mild depression; 10-14 = Moderate depression; 15-19 = Moderately severe depression): (P) 14

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?: (P) Not difficult at all

GAD-7 Total Score: (P) 12

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

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?: (P) Not difficult at all

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.

WSAS Total:: (Patient-Rptd) (P) 22

Mental Status Examination:

Appearance: appropriate

Attention: normal

Interview behavior: cooperative

Orientation: time, place, and person

Mood: "good"; euthymic

Affect: appropriate

Thought process: circumstantial

Insight: fair

Judgment: fair

Impulse control: intact

Sleep: no change

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 treating symptoms of depression and anxiety. Processed the client's interest in a diagnosis of ADHD, and explored symptoms that he experiences that coincide with a diagnosis of ADHD. Based on current self-report, client does not meet criteria for an ADHD diagnosis. Discussed how client's symptoms

of depression, anxiety, and TBI could also contribute to his experience of symptoms that co-occur with ADHD. Provided psychoeducation regarding the process of undergoing formal assessment for ADHD. Discussed client's experience of anger, and explored strategies to help manage anger, including utilizing TIPP skills to cope with symptoms of distress, as well as the client taking an inventory of experiences and circumstances that could potentially lead to the client experiencing anger. Explored client's openness to working with a psychiatrist to help address his presenting concerns and symptoms of distress. Client noted that he would reflect on this between appointments. Client ended the appointment by expressing concern regarding low motivation, and connected this to feelings of fear. Client and therapist agreed to continue this conversation at the next appointment. 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 processing the client's experience and expression of emotions. 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.