

## Victoria Fursov

Student in GCN 601 NLS Principles & Methods of Counseling Livestream  
Adjunct Professor: Dr. Azilde Sanchez, PhD., LPC., LCADC., ACS  
Masters in Mental Health Counseling Program  
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### Intake Report

#### **CONFIDENTIAL**

Client Name:	Kate Shellstrop	Supervisor's Name:	Dr. Azilde Sanchez, PhD., LPC., LCADC., ACS
Address:	2 Washington Street	Date of Interview:	02/22/2023
Gender:	New York, NY 10004	Date Report Written:	03/06/2023
DOB:	Female	Date Report Submitted:	03/08/2023
	October 12, 1998		
Highest Level of Education:	Bachelors		
Current Employment Status:	employed		
Current Marital Status:	Single		
Examiner's Name:	Victoria Fursov		

#### **Referral and Purpose of Evaluation:**

Client was referred by friend for her excessive worrying and unable to control her thoughts. Client's symptoms are causing significant distress and impairment in occupational and social areas of functioning.

#### **Description of Client/Behavioral Observations:**

The client is a 25 year old female of white ethnic background. The client was born Upstate New York, and remains single. Highest educational level is a bachelors degree in business administration. The client is a child of five, and is the oldest of the family having two sisters and two brothers. The client is currently living in a shared apartment in New York City, having one female roommate. The client's presentation during the interview was casual and appropriate. She appeared neat, and her mannerisms were stiff. Observed behaviors of the clients were cooperative, a little nervous, no pacing or bizarre behaviors were seen. The client spoke clearly with no foreign accent. Degree of eye contact was appropriate and the client presented with no stuttering. Additionally, The only sources of information was the client directly, with the exception of the referral from a friend. No information was gathered from the friend or court reports, school reports, and/or hospital records or documents.

#### **Presenting Problem:**

The client's presenting problem is excessive and persistent anxiety and worrying about her loved ones dying. The client is experiencing restlessness, difficulty concentrating, irritability and difficulty sleeping. Date of onset was 12 months prior. Client is experiencing symptoms more often than not, with the distress interfering with her occupational duties. The client has been experiencing mood changes with more frequent irritability. The client's expressed these symptoms are having a negative impact on her relationships with family and friends as well as ability to perform at her job. Lastly, the client has no current concomitant medical or psychiatric illnesses and is not undergoing any treatments, including alternative medicine approaches.

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**History of the Illness and Other Relevant History:**

The client began experiencing excessive and persistent worrying last March of 2022. She feels the constant need to call and check on her mother and grandparents to make sure they are alive. The Client lost her father at a young age and stated she mourned his death and was able to move on, otherwise the client had a healthy upbringing with no significant distress. The Client has no previous medical and/or psychiatric history of treatments. The client is the oldest in the family followed by a brother, two sisters, and a brother. Rearing environment was Upstate New York where the client was born and raised. No significant events in early childhood, The Client lost her father during middle childhood, and during adolescence, experienced her mother going back to work from being a stay at home mom. The Client worked at a local Ice cream shop during her high school years, no prior work history was noted. The Client's current occupation is an office administrative manager. The client remains single and has no history of dating/marriage. No history of substance use/abuse, no sexual history. The Client has one close friend who is also her coworker. The client had a few friends in her early adolescence whom she has since grown apart from. The client has no history of legal criminal activity, and has a clean medical history with the exception of a broken ankle at the age of ten. The client currently attends church on Sundays and grew up attending church with her family. Leisure activities the client participates in include reading, going on walks and going to the movies. No family history of psychiatric illness/problems. Lastly, the client has no history of physical or sexual abuse, sexual assault, or intimate partner violence such as date rape and domestic violence.

**Mental Status Examination:**

The client's appearance was neat with normal speech and eye contact. She was orientated to person, place, and time. The Client's mood was anxious with an appropriate affect; speech was at a normal rate and organization of thought was clear. The client was alert and aware of their environment and body. She was able to remain focused. The Client was able to recall events that happened in the recent past and in her childhood. The client had fair judgment with good insight into problems; The client had no suicidal and homicidal ideation, plan or intent. Client reported absence of hallucinations and delusional beliefs; and denied the use/abuse of alcohol, prescription drugs, street drugs, and herbs. Lastly, the client's strengths include an interest in learning and motivation to get better, a healthy self-esteem was noted. The client reported she is a christian believer, and has a small but supportive social circle. The client's history of coping and management of life proved that she is capable of overcoming adverse events.

**Clinical Formulation:**

The Client is a 25- year - old Female presenting with excessive worry, restlessness, difficulty concentrating, irritability and difficulty sleeping. Her symptoms began twelve months ago and she reports significant distress and impairment in her ability to function at work and her relationships. The clients symptoms fit criteria A, B, C, with more than three associated symptoms, D, E and F which leads to the tentative or working diagnoses of Generalized Anxiety Disorder. Differential diagnoses considered include other anxiety disorders, Obsessive-compulsive disorder, as well as Post traumatic stress disorder from the client experiencing her father passing away.

**DSM-5 Diagnosis:**

- F41.1 Generalized Anxiety Disorder
- F41.9 Unspecified Anxiety Disorder
- R/O F42.2 Obsessive-Compulsive Disorder
- R/O F43.10 Post traumatic Stress Disorder

**Tentative Treatment Plan and Goals:**

In light of the tentative diagnosis and clinical data presented in the assessment, treatment recommendation includes 15-session combination of cognitive-behavioral individual psychotherapy and Motivational interviewing with followup assessment for use of medications. Additionally, the tentative short term goals of treatment will be focused on modifying negative thinking patterns, reduction in worry and general distress. Suggestions for the use of CBT are based off a meta analysis performed by Hanrahan et al., where large effect sizes were found for the "efficacy of cognitive therapy in reducing worry at post treatment and 12-month followup" (Hanrahan et al., 2012)

**Signature and Title:**

Victoria Fursov



Supervisor's Name: Dr. Azilde Sanchez, PhD., LPC., LCADCS., ACS

**Appendix:**

a good portion of the above information can be found in the following reference:

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.).

Craighead, W. E., Miklowitz, D. J., & Craighead, L. W. (2013). Psychopathology: History, diagnosis, and empirical foundations. John Wiley & Sons.

Segal, D. (1998). Writing up the intake interview. In M. Herson, & V. B. Van Hasselt (Eds.),

*Basic interviewing: A practical guide for counselors and clinicians* (pp.129-150). USA: Lawrence Erlbaum Associates.