

NRNP/PRAC 6635 Comprehensive Psychiatric Evaluation Template

Subjective:

CC (chief complaint): “I’m just not doing so well... I’m just down” (Symptom Media, 2016, 00:00:45).

HPI: M.H is a young adult female with an academic history presenting for psychiatric evaluation for worsening low mood. She currently does not take psychotropic medication. Since around October, she has been feeling somewhat down, which her mother says happens every fall and winter (Symptom Media, 2016, 00:00:20–00:00:50). This includes hypersomnia, sleeping through five classes, weight gain of ten pounds and very impaired concentration. She forgets headlines within seconds of reading them and forgets what went on in class (Symptom Media, 2016, 00:02:25–00:03:20). She has been withdrawn from a specialized business program and is late on two projects. In August, she was easily making friends but now finds them obnoxious and boring, not going to concerts and outings (Symptom Media, 2016, 00:03:25–00:04:45). She claims that the gloomy dark season will effect her mood, whereas summer is a more preferred setting for her. There were no thoughts of suicide or self-harm.

Past Psychiatric History:

- **General Statement:** No previous psychiatric medical history indicated. Patient’s mother brings attention to a yearly trend that may indicate past cases of seasonal depressive episodes.
- **Caregivers** (if applicable): Referral initiated by patient’s mother.
- **Hospitalizations:** None

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- **Medication trials:** None
- **Psychotherapy or Previous Psychiatric Diagnosis:** None

Substance Current Use and History: Denies alcohol or illicit substance or nicotine or caffeine use. No history of withdrawal.

Family Psychiatric/Substance Use History: Not disclosed. It is clinically meaningful to collect information due to the presence of a recurrent seasonal mood pattern, which may reflect a family history.

Psychosocial History: The patient moved to an urban environment in August. Student is performing badly academically. Stops doing things she enjoyed before. No history of legal problems or trauma. There are two notable stressors; urban winter environment and academic transition.

Medical History: No Chronic Illness, Seizures or head injury.

- **Current Medications:** None
- **Allergies:** No known allergies. Assessment should be performed prior to drug therapy.
- **Reproductive Hx:** Reproductive History: Not reported. Assessing the LMP, contraceptive use, and pregnancy status. Given the person's age and sex, it is clinically relevant.

ROS:

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- GENERAL: Fatigue; 10 pound weight increase No fever and no chills.
- HEENT: No visual or auditory disturbances; No congestion.
- SKIN: No irritations.
- CARDIOVASCULAR: No chest pain or palpitation.
- RESPIRATORY: Breathing problems were absent.
- GASTROINTESTINAL: Increased appetite with weight gain. Feeling fine with no nausea or vomiting.
- GENITOURINARY: No urinary complaints.
- NEUROLOGICAL: Difficulty with concentration and short-term memory. No headache or dizziness.
- MUSCULOSKELETAL: no joint pain
- HEMATOLOGIC: No bleeding, no bruise
- LYMPHATICS: There is no swelling in the lymph nodes.
- ENDOCRINOLOGIC: The thyroid function must be screened due to hypersomnia and hyperphagia.

Objective:

Physical exam: No formal exam was conducted. The young adult female seems to be the age she says she is. The patient is dressed casually and is well-groomed. The psychomotor impairment is manifested by the patient's slouched position, sluggish speech, flat affect, absence of eye contact, frequent sighing, and delayed response. There is no abnormal movement observed.

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Diagnostic results: Diagnosis results no lab available. It is recommended CBC, CMP, TSH/free T4 to rule out anemia or hypothyroidism; a vitamin D level for the seasonal/light-related presentation; a PHQ-9 and a Seasonal Pattern Assessment Questionnaire (SPAQ) to objectively quantify severity (Spurny-Dworak et al., 2026); and a urine drug screen to rule out substance contribution.

Assessment:

Mental Status Examination: Evaluation of mental state: M.H. is a young female adult who looks her age. The patient is cooperative but somewhat subdued with low energy, and a flat affect that is congruent with the mood. She is well-groomed. Psychomotor impairment may be assessed according to one's slowed speech, response latency, and slumped posture. She finds it difficult to articulate. Effective communication is clear and goal-directed, with a low intensity and tone. The thoughts are reasonable; there is no flight of ideas, and no loose association. No delusional ideation is evident in the person's thought content. No hearing or seeing things triggered. She does not think about self-harm or anyone else. Although she appears alert and fully aware of her surroundings, she complains of difficulty concentrating and struggling to recall information she learned yesterday. She downplays the limits of insight as seasonal. Judgment is sufficient.

Differential Diagnoses:

1. **Major Depressive Disorder (MDD), Recurrent, with Seasonal Pattern (Primary)**

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M.H meets a number of DSM-5-TR Criterion A symptoms, including depressed mood, hypersomnia, weight gain, diminished concentration, and anhedonia, with clear impairment of function (APA, 2022). The yearly occurrence related with the onset of fall/winter supports the “with seasonal pattern” specifier. Studies show that there are lower hippocampal GABA concentrations in SAD, which aligns with the general MDD pathology (Spurny-Dworak et al., 2026). According to Lam et al. (2024), evidence-based treatment in recurrent MDD includes psychotherapy and pharmacotherapy as per CANMAT 2023 guidelines. The presence of negative symptoms also meant no manic or hypomanic history making diagnosis of bipolar disorder to be struck out.

2. Persistent Depressive Disorder (PDD)

Individuals suffering from PDD experience depressed mood for two years, for greater than half the days, along with at least two other symptoms (APA, 2022). The mood pattern of M.H. seems to be recurrent; however, the symptoms, although episodic, seasonally circumscribed, and not continuous for a two-year period required for this diagnosis. The extent to which her academic plan and classes are disrupted exceeds the parsimonious presentation of PDD. Additional longitudinal history will help confirm complete inter-episode remission in summer months making this diagnosis a differential.

3. Bipolar II Disorder, Current Depressive Episode 📌

Since major depressive episodes predominate its clinical picture, and because there is some overlap with seasonal pattern and atypical depressive features (i.e., hypersomnia and hyperphagia) with M.H.’s current profile (APA, 2022). The 2023 CANMAT guidelines specifically warn that when patients come in exclusively during

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depressive episodes, the bipolar II diagnosis is often made in error, which is especially the case as the first episode is generally depressive (Lam et al., 2024). Hypomania is not seen in this patient either in the interview nor mentioned by her mother. As such, considering that there is no evidence of elevated mood, grandiosity, insomnia, and increase in goal-directed activities, a diagnosis of hypomania is unlikely.


Reflections:

If this session of structured validated tools, such as the PHQ-9 and SPAQ, were to repeat, these will be administered at the very beginning. This would allow for an objective quantification of symptom severity and the degree of seasonality. A comprehensive family psychiatric history, detailed reproductive history, and allergy assessment would also take priority before any drug decisions. These are clinically relevant gaps in the assessment in its current format. The lack of allergy information is particularly noteworthy given NICE (2022) guidance, which states that medication safety planning is a fundamental step in managing depression.

As a matter of ethics, the referral was made by the mother, who may be in a position to provide useful collateral history. Nonetheless, we must protect the patient's confidentiality and the mother must not violate the patient's right to autonomous decision making. Accordingly, any disclosure of session content with family members must be done with the permission of the patient. Furthermore, one must maintain and revisit the duty-to-warn obligations, safety planning documentation, and scope-of-practice as a PMHNP if future sessions reveal suicidal ideation. We must also consider age and institutional characteristics in mandatory reporting assessments.

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M.H. is healthy in promotion perspective. A major transition is noted given the change in the academic environment, social isolation, moving away from home and reduced daylight hours. Light therapy is the most effective intervention for treating SAD, and there is ample efficacy evidence available in this regard (Spurny-Dworak et al., 2026). Moreover, according to NICE (2022), the primary line of treatment for depression in young adults involves the use of cognitive-behavioral therapy and behavioral activation interventions. Her treatment plan will consist of exercise, good sleep, and social engagement. It is necessary to improve her limited insight and foster adherence to treatment by psychoeducation regarding the seasonal and neurobiological nature of her symptoms (Lam et al., 2024).



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References

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