State of California
Division of Worker's Compensation
PHYSICIAN'S PROGRESS REPORT (PR2)
Hinze Psychological Services

DOI:07/11/2012

{ }Periodic Report (required 45 days after last report) { }Change in treatment plan { }Release from care
{ }Change in Work Status { }Need for referral or consultation { }Response to request for authorization
{ }Change in Patient's Condition { }Need for surgery or hospitalization { }Request for authorization {x}Other: Sec. Treating Phys. Report

Patient :
Last: **DORAN** First: **Daniel** M.I: Sex: male D.O.B: 06/04/1966
Address:1245 W Cienega Spc# 201 City: San Dimas State:CA Zip:91733
SS# 554-73-1885 Phone: 760-258-7545

Claims Administrator: Emma, Padilla
Name: **State Compensation Ins. Fund - LA** Claim Number:**05814232**
Address: P.O. Box 65005 City: Fresno, CA 93650
Phone : 888-782-8338 Fax: --

Employer Name: Benedict & Benedict Phone:

Subjective Complaints: The information below must be provided. You may use this form or you may substitute or append a narrative report.
Pt reports: Anger, Anxiety, Inability to gain pleasure in life.

Objective: (Include significant physical examination, laboratory, imaging or other diagnostic findings.
Pt appears: Angry, Depressed, Hopeless Affect is: Restricted Pt. was administered: BAI: Severe 41 BDI: Severe 49.

Diagnosis:
300.00 Anxiety Disorder, NOS 311 Depressive Disorder, NOS 780.52 Sleep Disorder Due to Pain, Insomnia Type

Treatment Plan: Authorization requested for 4 sessions of cognitive behavioral therapy and relaxation training sessions.
[ ] TRANSPORTATION: As a result of this industrial injury (including his physical/psychological condition and or use of medications) this patient requires provisions for provided private transportation. This will include to evaluations and supervised treatment until further notice.

Work Status: Work status will be directed by PTP.

Secondary Treating Physician: **Hinze Psychological Services** **Date of Exam:** dec 10, 2013
I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code 139.3

Signature:

Heath Hinze, Psy.D.
Specialty: **Clinical Psychologist CA #: PSY23840**
Address : **724 Corporate Center Drive Pomona, CA 91768**
Tel: **(909) 622-6222**

Marsinah Ramirez Trujillo
Register MFT Int #62969

DWC Form PR-2
(Rev. 06-05)

NOTES

Name: Daniel DORAN Acct. # 20015038 Date: 12/10/2013

O/S - Client was quiet.

A - Client used this session to listen to others & reflect on his own management of emotions. Client asked why Dr. H has not seen him. Referred Client to 4/3

P - Continue CBT

BDI-II

Date: 12/10/13

Name: Daniel Doran Marital Status: W Age: 47 Sex: M

Occupation: JOURNEYMAN PLUMBER Education: YES

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the one statement in each group that best describes the way you have been feeling during the past two weeks, including today. Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

1. Sadness

0 I do not feel sad.
1 I feel sad much of the time.
(2) I am sad all the time.
3 I am so sad or unhappy that I can't stand it.

2. Pessimism

0 I am not discouraged about my future.
1 I feel more discouraged about my future than I used to be.
(2) I do not expect things to work out for me.
3 I feel my future is hopeless and will only get worse.

3. Past Failure

0 I do not feel like a failure.
1 I have failed more than I should have.
(2) As I look back, I see a lot of failures.
3 I feel I am a total failure as a person.

4. Loss of Pleasure

0 I get as much pleasure as I ever did from the things I enjoy.
1 I don't enjoy things as much as I used to.
2 I get very little pleasure from the things I used to enjoy.
(3) I can't get any pleasure from the things I used to enjoy.

5. Guilty Feelings

0 I don't feel particularly guilty.
1 I feel guilty over many things I have done or should have done.
(2) I feel quite guilty most of the time.
3 I feel guilty all of the time.

6. Punishment Feelings

0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
(3) I feel I am being punished.

7. Self-Dislike

0 I feel the same about *myself* as ever.
1 I have lost confidence in myself.
(2) I am disappointed in myself.
3 I dislike myself.

8. Self-Criticalness

0 I don't criticize or blame myself more than usual.
1 I am more critical of myself than I used to be.
2 I criticize myself for all of my faults.
(3) I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes

0 I don't have any thoughts of killing myself.
(1) I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

10. Crying

0 I don't cry anymore than I used to.
1 I cry more than I used to.
2 I cry over every little thing.
(3) I feel like crying, but I can't.

Continued on Back

Subtotal Page 1

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Harcourt Brace & Company

11. Agitation

0 I am no more restless or wound up than usual.
1 I feel more restless or wound up than usual.
2 I am so restless or agitated that it's hard to stay still.
(3) I am so restless or agitated that I have to keep moving or doing something.

12. Loss of Interest

0 I have not lost interest in other people or activities.
1 I am less interested in other people or things than before.
2 I have lost most of my interest in other people or things.
(3) It's hard to get interested in anything.

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0 I make decisions about as well as ever
1 I find it more difficult to make decisions than usual.
2 I have much greater difficulty in making decisions than I used to.
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14. Worthlessness

0 I do not feel I am worthless.
(1) I don't consider myself as worthwhile and useful as I used to
2 I feel more worthless as compared to other people.
3 I feel utterly worthless.

15. Loss of Energy

0 I have as much energy as ever.
1 I have less energy than I used to have.
(2) I don't have enough energy to do very much.
3 I don't have enough energy to do anything.

16. Changes in Sleeping Pattern

0 I have not experienced any change in my sleeping pattern.
1a I sleep somewhat more than usual.
1b I sleep somewhat less than usual.
2a I sleep a lot more than usual.
(2b) I sleep a lot less than usual.
3a I sleep most of the day.
3b I wake up 1–2 hours early and can't get back to sleep.

17. Irritability

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(2) I am much more irritable than usual.
3 I am irritable all the time.

18. Changes in Appetite

0 I have not experienced any change in my appetite.
1a My appetite is somewhat less than usual.
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2a My appetite is much less than before.
2b My appetite is much greater than usual.
(3a) I have no appetite at all.
3b I crave food all the time.

19. Concentration Difficulty

0 I can concentrate as well as ever.
1 I can't concentrate as well as usual.
(2) It's hard to keep my mind on anything for very long.
3 I find I can't concentrate on anything.

20. Tiredness or Fatigue

0 I am no more tired or fatigued than usual.
1 I get more tired or fatigued more easily than usual.
(2) I am too tired or fatigued to do a lot of the things I used to do.
3 I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex

0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex now.
(3) I have lost interest in sex completely.

15 16 17 18 19 20 A B C D E

49

Subtotal Page 2

Subtotal Page 1

Total Score

NAME _____ DATE _____

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by e symptom during the PAST WEEK, INCLUDING TODAY, by placing an X in the corresponding space in the column next to each symp

	NOT AT ALL	MILDLY	MODERATELY	SEVERELY
1. Numbness or tingling.		X		
2. Feeling hot.			X	
3. Wobbliness in legs.			X	
4. Unable to relax.				X
5. Fear of the worst happening.				X
6. Dizzy or lightheaded.			X	
7. Heart pounding or racing.			X	
8. Unsteady.			X	
9. Terrified.			X	
10. Nervous.				X
11. Feelings of choking.	X			
12. Hands trembling.			X	
13. Shaky.		X		
14. Fear of losing control.			X	
15. Difficulty breathing.		X		
16. Fear of dying.				X
17. Scared.			X	
18. Indigestion or discomfort in abdomen.				X
19. Faint.		X		
20. Face flushed.			X	
21. Sweating (not due to heat).			X	

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41

(1)

NOTES

Name: Daniel DORAN Acct. # 20015038 Date: 12/03/2013

S – Client discussed his way of fighting to resolve conflict & saw this as a value of being harsh.

O – Engaged.

A – Client continues to discuss difficult feelings & looks to resolve ways to manage emotions.

P – Continue CBT

NOTES

Name: Daniel DORAN Acct. # 20015038 Date: 11/26/2013

S- Client discussed frustration of VE systems

O. Engaged

A- client is motivated to make changes of Attorney because of reported lack of service. Client is striving to advocate for his oral health

P- Continue CBT.

NOTES

Name: Daniel DORAN Acct. # 20015038 Date: 11/12/2013

5 – Client chose to be quiet in group

0 – Quiet

x – Client attends regularly but chooses at times to not talk

p – Contact CBT

BDI-II

Date: 4/12/13

Name: Daniel Doran Marital Status: W Age: 47 Sex: M

Occupation: JOURNEYMAN PLUMBER Education: YES

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____ Subtotal Page 1

Continued on Back

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15 16 17 18 19 20 A B C D E

Subtotal Page 2
Subtotal Page 1
Total Score

44

NAME D. DORAN DATE 11/12/13

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by e symptom during the PAST WEEK, INCLUDING TODAY, by placing an X in the corresponding space in the column next to each symp

	NOT AT ALL	MILDLY	MODERATELY	SEVERELY
1. Numbness or tingling.		X		
2. Feeling hot.			X	
3. Wobbliness in legs.		X		
4. Unable to relax.				X
5. Fear of the worst happening.				X
6. Dizzy or lightheaded.	X			
7. Heart pounding or racing.		X		
8. Unsteady.			X	
9. Terrified.		X		
10. Nervous.				X
11. Feelings of choking.	X			
12. Hands trembling.			X	
13. Shaky.			X	
14. Fear of losing control.			X	
15. Difficulty breathing.		X		
16. Fear of dying.			X	
17. Scared.			X	
18. Indigestion or discomfort in abdomen.				X
19. Faint.		X		
20. Face flushed.			X	
21. Sweating (not due to heat).			X	

(1)

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State of California
Division of Worker's Compensation
PHYSICIAN'S PROGRESS REPORT (PR2)
Hinze Psychological Services

DOI:07/11/2012

{ }Periodic Report (required 45 days after last report) { }Change in treatment plan { }Release from care
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Patient :
Last: DORAN First: Daniel M.I: Sex: male D.O.B: 06/04/1966
Address:1245 W Cienega Spc# 201 City: San Dimas State:CA Zip:91733
SS# 554-73-1885 Phone: 760-258-7545

Claims Administrator: Emma, Padilla
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Employer Name: Benedict & Benedict Phone:

Subjective Complaints: The information below must be provided. You may use this form or you may substitute or append a narrative report.
Pt reports: Anger, Anxiety, Inability to gain pleasure in life.

Objective: (Include significant physical examination, laboratory, imaging or other diagnostic findings.
Pt appears: Angry, Depressed, Fearful, Hopeless Affect is: Restricted Pt. was administered: BAI: Severe 36 BDI: Severe 44.

Diagnosis:
300.00 Anxiety Disorder, NOS 311 Depressive Disorder, NOS 780.52 Sleep Disorder Due to Pain, Insomnia Type

Treatment Plan: Authorization requested for 4 sessions of cognitive behavioral therapy and relaxation training sessions.

[x] TRANSPORTATION: As a result of this industrial injury (including his physical/psychological condition and or use of medications) this patient requires provisions for provided private transportation. This will include to evaluations and supervised treatment until further notice.

Work Status: Work status will be directed by PTP.

Secondary Treating Physician: **Hinze Psychological Services** **Date of Exam:** nov 12, 2013
I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code 139.3

Signature:

Heath Hinze, Psy.D.
Specialty: **Clinical Psychologist CA #: PSY23840**
Address : **724 Corporate Center Drive Pomona, CA 91768**
Tel: **(909) 622-6222**

Marsinah Ramirez Trujillo
Register MFT Int #62969

DWC Form PR-2
(Rev. 06-05)

NOTES

Name: Daniel DORAN Acct. # 20015038 Date: 10/29/2013

S- Client discussed ruminations about former boss-

O- SAD, upset, angry

A- Client examined why his SXS have increased + said that his financial situation is dire, + that has prompted him to ruminate over Bosses' actions. I- Asked Client if ruminations exacerbated urges + he affirmed this, making motivational statement that "he should try to distract self" from maladaptive thoughts.

P- Continue CBT

NOTES

Name: Daniel DORAN Acct. # 20015038 Date: 10/22/2013

S- Client discussed frustration w/ the system.

O- Engaged; Client was open to considering impact of dist/neg thoughts.

A- Client continues to explore how maladaptive thoughts r/s sys & is at place of considering alternative Bx to d neg thoughts.

P- Continue CBT

NOTES

Name: Daniel DORAN Acct. # 20015038 Date: 10/08/2013

S – Client discussed his sense of hopelessness, stating he has reached out for help & no one has been there to help him.

O – Hopeless, extreme despair (Depression);

A – Client is struggling with day-to day-living activities because he feels hopeless about life. He states everything takes more effort & feels disappointed in his capabilities. Client has made motivating statements that he needs to be stronger.

P – Continue CBT

Client reports having a panic Attack, feeling that senses were extremely intense. reports feels
→ Sweating
→ ~~feels cold~~ felt dizzy
→ thought he was going to have a heart attack
→ NOTE – Client's symptoms appear to fall within criteria for Panic Disorder.

BDI-II

Date: 10.8.13.

Name: Daniel Doran. Marital Status: W Age: 47 Sex: M

Occupation: PLUMBER Education: YES

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Continued on Back

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15 16 17 18 19 20 A B C D E

Subtotal Page 2

Subtotal Page 1

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3. Wobbliness in legs.		X		
4. Unable to relax.				X
5. Fear of the worst happening.			X	
6. Dizzy or lightheaded.			X	
7. Heart pounding or racing.			X	
8. Unsteady.		X		
9. Terrified.	X			
10. Nervous.				X
11. Feelings of choking.	X			
12. Hands trembling.			X	
13. Shaky.			X	
14. Fear of losing control.		X		
15. Difficulty breathing.		X		
16. Fear of dying.				X
17. Scared.	X			
18. Indigestion or discomfort in abdomen.				X
19. Faint.		X		
20. Face flushed.		X		
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THE PSYCHOLOGICAL CORPORATION
Harcourt Brace & Company
SAN ANTONIO

(1)

38

State of California
Division of Worker's Compensation
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Hinze Psychological Services

DOI:07/11/2012

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{ }Change in Patient's Condition { }Need for surgery or hospitalization { }Request for authorization {x}Other: Sec. Treating Phys. Report

Patient :
Last: DORAN First: Daniel M.I: Sex: male D.O.B: 06/04/1966
Address:1245 W Cienega Spc# 201 City: San Dimas State:CA Zip:91733
SS# 554-73-1885 Phone: 760-258-7545

Claims Administrator: Emma, Padilla
Name: State Compensation Ins. Fund - LA Claim Number:05814232
Address: P.O. Box 65005 City: Fresno, CA 93650
Phone : 888-782-8338 Fax: --

Employer Name: Benedict & Benedict Phone:

Subjective Complaints: The Information below must be provided. You may use this form or you may substitute or append a narrative report.
Pt reports: Anger, Anxiety, Fear, Feeling hopeless, Inability to gain pleasure in life.

Objective: (Include significant physical examination, laboratory, imaging or other diagnosticfindings.
Pt appears: Angry, Depressed, Fearful, Hopeless Affect is: Restricted Pt. was administered: BAI: Severe 32 BDI: Severe 41.

Diagnosis:
311 Depressive Disorder, NOS 300.00 Anxiety Disorder, NOS 780.52 Sleep Disorder Due to Pain, Insomnia Type

Treatment Plan: Authorization requested for 4 sessions of cognitive behavioral therapy and relaxation training sessions.

[x] TRANSPORTATION: As a result of this industrial injury (including his physical/psychological condition and or use of medications) this patient requires provisions for provided private transportation. Thiswill include to evaluations and supervised treatment until further notice.

Work Status: Work status will be directed by PTP.

Secondary Treating Physician: **Hinze Psychological Services** **Date of Exam:** oct 08, 2013

I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code 139.3

Signature:

Heath Hinze, Psy.D.
Specialty: **Clinical Psychologist CA #: PSY23840**
Address : **724 Corporate Center Drive Pomona, CA 91768**
Tel: **(909) 622-6222**

Marsinah Ramirez Trujillo
Register MFT Int #62969

DWC Form PR-2
(Rev. 06-05)

NOTES

Name: Daniel DORAN Acct. # 20015038 Date: 09/17/2013

S - Client did not speak

O - Client actively listened,

A - Client attends regularly + appears to benefit by listening to others concerns/stories

P - Continue CBT

NOTES

Name: Daniel DORAN Acct. # 20015038 Date: 09/10/2013

S - Client chose to not speak

O - Appeared to be listening, but not verbal

A - Client has missed previous session & appears has slow to warm up to groups
Encouraged & educated client on necessity of treatments

P - Continue CBT

BDI-II

Date: 9-10-13.

Name: Daniel Doran. Marital Status: W Age: 47 Sex: M

Occupation: JOURNEYMAN PLUMBER Education: YES

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the one statement in each group that best describes the way you have been feeling during the past two weeks, including today. Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

1. Sadness

0 I do not feel sad.
(1) I feel sad much of the time.
2 I am sad all the time.
3 I am so sad or unhappy that I can't stand it.

2. Pessimism

0 I am not discouraged about my future.
1 I feel more discouraged about my future than I used to be.
(2) I do not expect things to work out for me.
3 I feel my future is hopeless and will only get worse.

3. Past Failure

0 I do not feel like a failure.
1 I have failed more than I should have.
(2) As I look back, I see a lot of failures.
3 I feel I am a total failure as a person.

4. Loss of Pleasure

0 I get as much pleasure as I ever did from the things I enjoy.
1 I don't enjoy things as much as I used to.
(2) I get very little pleasure from the things I used to enjoy.
3 I can't get any pleasure from the things I used to enjoy.

5. Guilty Feelings

0 I don't feel particularly guilty.
(1) I feel guilty over many things I have done or should have done.
2 I feel quite guilty most of the time.
3 I feel guilty all of the time.

6. Punishment Feelings

0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
(3) I feel I am being punished.

7. Self-Dislike

0 I feel the same about myself as ever.
1 I have lost confidence in myself.
2 I am disappointed in myself.
(3) I dislike myself.

8. Self-Criticalness

0 I don't criticize or blame myself more than usual.
1 I am more critical of myself than I used to be.
(2) I criticize myself for all of my faults.
3 I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes

0 I don't have any thoughts of killing myself.
(1) I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

10. Crying

0 I don't cry anymore than I used to.
(1) I cry more than I used to.
2 I cry over every little thing.
3 I feel like crying, but I can't.

____ Subtotal Page 1

Continued on Back

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11. Agitation

0 I am no more restless or wound up than usual.
1 I feel more restless or wound up than usual.
(2) I am so restless or agitated that it's hard to stay still.
3 I am so restless or agitated that I have to keep moving or doing something.

12. Loss of Interest

0 I have not lost interest in other people or activities.
1 I am less interested in other people or things than before.
2 I have lost most of my interest in other people or things.
(3) It's hard to get interested in anything.

13. Indecisiveness

0 I make decisions about as well as ever
1 I find it more difficult to make decisions than usual.
(2) I have much greater difficulty in making decisions than I used to.
3 I have trouble making any decisions.

14. Worthlessness

0 I do not feel I am worthless.
1 I don't consider myself as worthwhile and useful as I used to.
(2) I feel more worthless as compared to other people.
3 I feel utterly worthless.

15. Loss of Energy

0 I have as much energy as ever.
1 I have less energy than I used to have.
(2) I don't have enough energy to do very much.
3 I don't have enough energy to do anything.

16. Changes in Sleeping Pattern

0 I have not experienced any change in my sleeping pattern.
1a I sleep somewhat more than usual.
1b I sleep somewhat less than usual.
2a I sleep a lot more than usual.
(2b) I sleep a lot less than usual.
3a I sleep most of the day.
3b I wake up 1–2 hours early and can't get back to sleep.

17. Irritability

0 I am no more irritable than usual.
1 I am more irritable than usual.
(2) I am much more irritable than usual.
3 I am irritable all the time.

18. Changes in Appetite

0 I have not experienced any change in my appetite.
1a My appetite is somewhat less than usual.
1b My appetite is somewhat greater than usual.
(2a) My appetite is much less than before.
2b My appetite is much greater than usual.
3a I have no appetite at all.
3b I crave food all the time.

19. Concentration Difficulty

0 I can concentrate as well as ever.
1 I can't concentrate as well as usual.
(2) It's hard to keep my mind on anything for very long.
3 I find I can't concentrate on anything.

20. Tiredness or Fatigue

0 I am no more tired or fatigued than usual.
1 I get more tired or fatigued more easily than usual.
2 I am too tired or fatigued to do a lot of the things I used to do.
(3) I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex

0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
(2) I am much less interested in sex now.
3 I have lost interest in sex completely.

15 16 17 18 19 20 A B C D E

Subtotal Page 2
Subtotal Page 1
Total Score

41

NAME _____ DATE _____

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by e symptom during the PAST WEEK, INCLUDING TODAY, by placing an X in the corresponding space in the column next to each symp

	NOT AT ALL	MILDLY	MODERATELY	SEVERELY
1. Numbness or tingling.		X		
2. Feeling hot.			X	
3. Wobbliness in legs.		X		
4. Unable to relax.				X
5. Fear of the worst happening.				X
6. Dizzy or lightheaded.		X		
7. Heart pounding or racing.			X	
8. Unsteady.		X		
9. Terrified.		X		
10. Nervous.				X
11. Feelings of choking.	X			
12. Hands trembling.			X	
13. Shaky.			X	
14. Fear of losing control.		X		
15. Difficulty breathing.		X		
16. Fear of dying.			X	
17. Scared.		X		
18. Indigestion or discomfort in abdomen.				X
19. Faint.	X			
20. Face flushed.			X	
21. Sweating (not due to heat).			X	

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34 (1)

State of California
Division of Worker's Compensation
PHYSICIAN'S PROGRESS REPORT (PR2)
Hinze Psychological Services

DOI:07/11/2012

{ }Periodic Report (required 45 days after last report) { }Change in treatment plan { }Release from care
{ }Change in Work Status { }Need for referral or consultation { }Response to request for authorization
{ }Change in Patient's Condition { }Need for surgery or hospitalization { }Request for authorization {x}Other: Sec. Treating Phys. Report

Patient :
Last: DORAN First: Daniel M.I: Sex: male D.O.B: 06/04/1966
Address:1245 W Cienega Spc# 201 City: San Dimas State:CA Zip:91733
SS# 554-73-1885 Phone: 760-258-7545

Claims Administrator: Emma, Padilla
Name: State Compensation Ins. Fund - LA Claim Number:05814232
Address: P.O. Box 65005 City: Fresno, CA 93650
Phone : 888-782-8338 Fax: --

Employer Name: Benedict & Benedict Phone:

Subjective Complaints: The Information below must be provided. You may use this form or you may substitute or append a narrative report.
Pt reports: Anger, Anxiety, Fear, Feeling hopeless, Inability to gain pleasure in life.

Objective: (Include significant physical examination, laboratory, imaging or other diagnosticfindings.
Pt appears: Depressed, Hopeless Affect is: Restricted Pt. was administered: BAI: Severe 34 BDI: Severe 41.

Diagnosis:

Treatment Plan: Authorization requested for 4 sessions of cognitive behavioral therapy and relaxation training sessions.

[x] TRANSPORTATION: As a result of this industrial injury (including is physical/psychological condition and or use of medications) this patient requires provisions for provided private transportation. Thiswill include to evaluations and supervised treatment until further notice.

Work Status: Work status will be directed by PTP.

Secondary Treating Physician: **Hinze Psychological Services** **Date of Exam:** sep 10, 2013
I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code 139.3

Signature:

Heath Hinze, Psy.D.
Specialty: **Clinical Psychologist CA #: PSY23840**
Address : **724 Corporate Center Drive Pomona, CA 91768**
Tel: **(909) 622-6222**

Marsinah Ramirez Trujillo
Register MFT Int #62969

DWC Form PR-2
(Rev. 06-05)

State of California
Division of Worker's Compensation
PHYSICIAN'S PROGRESS REPORT (PR2)
Hinze Psychological Services

DOI:07/11/2012

{ }Periodic Report (required 45 days after last report) { }Change in treatment plan { }Release from care
{ }Change in Work Status { }Need for referral or consultation { }Response to request for authorization
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Patient :
Last: **DORAN** First: **Daniel** M.I: Sex: male D.O.B: 06/04/1966
Address:1245 W Cienega Spc# 201 City: San Dimas State:CA Zip:91733
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Employer Name: Benedict & Benedict Phone:

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Pt reports: Anger, Anxiety, Fear, Feeling hopeless, Inability to gain pleasure in life.

Objective: (Include significant physical examination, laboratory, imaging or other diagnostic findings.
Pt appears: Angry, Anxious, Depressed, Hopeless Affect is: Normal Pt. was administered: BAI: Severe 37 BDI: Severe 41.

Diagnosis:
300.00 Anxiety Disorder, NOS 311 Depressive Disorder, NOS

Treatment Plan: Authorization requested for 4 sessions of cognitive behavioral therapy and relaxation training sessions.

[x] TRANSPORTATION : As a result of this industrial injury (including his physical/psychological condition and or use of medications) this patient requires provisions for provided private transportation. This will include to evaluations and supervised treatment until further notice.

Work Status: Work status will be directed by PTP.

Secondary Treating Physician: **Hinze Psychological Services** **Date of Exam:** aug 06, 2013
I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code 139.3

Signature:

Heath Hinze, Psy.D.
Specialty: **Clinical Psychologist CA #: PSY23840**
Address : **724 Corporate Center Drive Pomona, CA 91768**
Tel: **(909) 622-6222**

Marsinah Ramirez Trujillo
Register MFT Int #62969

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(Rev. 06-05)

State of California
Division of Worker's Compensation
PHYSICIAN'S PROGRESS REPORT (PR2)
Hinze Psychological Services

DOI:07/11/2012

{ }Periodic Report (required 45 days after last report) { }Change in treatment plan { }Release from care
{ }Change in Work Status { }Need for referral or consultation { }Response to request for authorization
{ }Change in Patient's Condition { }Need for surgery or hospitalization { }Request for authorization {x}Other: Sec. Treating Phys. Report

Patient :
Last: DORAN First: Daniel M.I: Sex: male D.O.B: 06/04/1966
Address: 1245 W Cienega Spc# 201 City: San Dimas State: CA Zip: 91733
SS# 554-73-1885 Phone: 760-258-7545

Claims Administrator: Emma, Padilla
Name: State Compensation Ins. Fund - LA Claim Number: 05814232
Address: P.O. Box 65005 City: Fresno, CA 93650
Phone : 888-782-8338 Fax: --

Employer Name: Benedict & Benedict Phone:

Subjective Complaints: The information below must be provided. You may use this form or you may substitute or append a narrative report.
Pt reports: Anger, Anxiety, Fear, Feeling hopeless, Inability to gain pleasure in life.

Objective: (Include significant physical examination, laboratory, imaging or other diagnostic findings.
Pt appears: Angry, Anxious, Depressed, Hopeless Affect is: Normal Pt. was administered: BAI: Severe 38 BDI: Severe 39.

Diagnosis:
300.00 Anxiety Disorder, NOS 311 Depressive Disorder, NOS

Treatment Plan: Authorization requested for 4 sessions of cognitive behavioral therapy and relaxation training sessions.

[x] TRANSPORTATION: As a result of this industrial injury (including his physical/psychological condition and or use of medications) this patient requires provisions for provided private transportation. This will include to evaluations and supervised treatment until further notice.

Work Status: Work status will be directed by PTP.

Secondary Treating Physician: **Hinze Psychological Services** **Date of Exam:** jul 09, 2013

I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code 139.3

Signature:

Heath Hinze, Psy.D.
Specialty: **Clinical Psychologist CA #: PSY23840**
Address : **724 Corporate Center Drive Pomona, CA 91768**
Tel: **(909) 622-6222**

Marsinah Ramirez Trujillo
Register MFT Int #62969

DWC Form PR-2
(Rev. 06-05)

- notes -

State of California
Division of Worker's Compensation
PHYSICIAN'S PROGRESS REPORT (PR2)
Hinze Psychological Services

DOI:07/11/2012

{ }Periodic Report (required 45 days after last report) { }Change in treatment plan { }Release from care
{ }Change in Work Status { }Need for referral or consultation { }Response to request for authorization
{ }Change in Patient's Condition { }Need for surgery or hospitalization { }Request for authorization {x}Other: Sec. Treating Phys. Report

Patient :
Last: **DORAN** First: **Daniel** M.I: Sex: male D.O.B: 06/04/1966
Address:1245 W Cienega Spc# 201 City: San Dimas State:CA Zip:91733
SS# 554-73-1885 Phone: 760-258-7545

Claims Administrator: Emma, Padilla
Name: **State Compensation Ins. Fund - LA** Claim Number:**05814232**
Address: P.O. Box 65005 City: Fresno, CA 93650
Phone : 888-782-8338 Fax: -- -

Employer Name: Benedict & Benedict Phone:

Subjective Complaints: The Information below must be provided. You may use this form or you may substitute or append a narrative report.
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Objective: (Include significant physical examination, laboratory, imaging or other diagnostic findings.
Pt appears: Angry, Anxious, Depressed, Hopeless Affect is: Normal Pt. was administered: BAI: Severe 39 BDI: Severe 41.

Diagnosis:
300.00 Anxiety Disorder, NOS 311 Depressive Disorder, NOS

Treatment Plan: Authorization requested for 4 sessions of cognitive behavioral therapy and relaxation training sessions.

[x] TRANSPORTATION: As a result of this industrial injury (including his physical/psychological condition and or use of medications) this patient requires provisions for provided private transportation. This will include to evaluations and supervised treatment until further notice.

Work Status: Work status will be directed by PTP.

Secondary Treating Physician: Hinze Psychological Services **Date of Exam:** jun 11, 2013
I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code 139.3

Signature:

Heath Hinze, Psy.D.
Specialty: **Clinical Psychologist CA #: PSY23840**
Address: **724 Corporate Center Drive Pomona, CA 91768**
Tel: **(909) 622-6222**

Marsinah Ramirez Trujillo
Register MFT Int #62969

Hinze Psychological Services, PC.

A Professional Corporation

Heath Hinze, Psy.D. *Clinical Psychologist*

Edwin Haronian, M.D.
724 Corporate Center Dr. 2nd Floor
Pomona, CA 91768

INITIAL COMPREHENSIVE PSYCHOLOGICAL CONSULTATION AND REPORT

Patient Name	**: DORAN, Daniel**
Claim Number	**: 05814232**
Social Security No	**: 554-73-1885**
D.O.B	**: 06/04/1966**
Employer	**: Benedict & Benedict**
Date Of Injury	**: 07/11/2012**
Date of Evaluation	**: May 7, 2013**

Dear Dr. Haronian:

I had the pleasure of seeing your patient for an initial psychological consultation. The entire evaluation was carried out at 724 Corporate Center Dr, Pomona, CA 91768 . The evaluation was carried to include psycho-diagnostic testing, scoring and interpretation.

This report contains material that may be misunderstood or misinterpreted by an examinee. For certain individuals, exposure could be destructive. If this report is to be discussed at all with the examinee, an appropriate professional who will ensure that the information is used therapeutically and not destructively should conduct it in a clinical setting. Please be advised that there is a duty to protect this material.

REPORT OF TIME SPENT:

(99358) Total time spent in prolonged non-face-to-face care including record review: _30_ Min.

(96100) Psychological Testing: Total time spent in the process of administration, scoring, interpreting and preparing results into the report: _420_ Min.

Before the examination began, the patient was informed of being evaluated exclusively in connection with the Workers' Compensation claim. The examinee was also made aware that any communication between us is not privileged (doctor-patient confidentiality) and that any information provided, as well as the results of the psychological testing and my conclusions regarding this case would be included in a report that may be read by people involved in the resolution and/or litigation of the claim. The examinee understood the aforementioned and agreed to proceed with the evaluation.

Identifying Information:

The patient is a 46 year-old male who worked as a plumber for Benedict & Benedict. The patient has suffered work injuries and is currently under the care of Dr. Haronian who has referred the patient today for a psychological evaluation.

Job Duties:

The patient began employment with Benedict & Benedict Plumbing in February 2010, as a Plumber.

He worked six to 12 hours per day, five days per week, and worked on call "a couple of days a week." His duties at the time of injury entailed: traveling to different job sites, loading and unloading material and tools from and onto a truck, carrying these to his immediate work site, repairing/removing/replacing toilets, sinks, bathtubs, and working on new water line and gas pipes. He was required to make holes on the ground and break walls. He utilized various hand-held and power tools.

The precise activities required entailed prolonged standing and walking, as well as continuous fine maneuvering of his hands and fingers, and repetitive bending, stooping, squatting, kneeling, crawling, twisting, turning, forceful pushing and pulling, forceful gripping and grasping, reaching to all levels, torqueing, lifting and carrying up to 100+ pounds, ascending and descending stairs and ladders.

History of the Injury as Provided by the Patient:
Mr. Doran is a 46-year-old right-hand-dominant male who sustained industrial injuries on July 11, 2012, while working as a Plumber for Benedict & Benedict Plumbing.

The patient states on July 11, 2012, during the course of his employment, he was making an opening on a section of a wall, requiring him using a saw to cut through. He states a chunk of wall from above came down and struck him on the right wrist and hand. He experienced immediate pain to his right wrist and hand and suffered an open wound to his right thumb. He washed it and put tape on it. He reported the injury to his supervisor and went home in pain. He had a restless night and returned to work the next day. He completed his shift in pain.

After a couple of days, he was provided with a helper and soon after referred for medical care. He was initially examined in the emergency room at Memorial Hospital in Pasadena. X-rays to his right wrist/hand and thumb were taken, consistent with a fracture in the right thumb. His right hand and thumb were splinted and taped. Within a week, he was examined by a company orthopedic surgeon. His right hand and thumb was set in a hard cast, which was removed in late September 2012. At that time his right hand was set in a removable cast. He had 12 sessions of physical therapy to his right wrist/hand and thumb, providing him temporary pain relief. He was last examined on February 8, 2013.

He remains off work since July 12, 2012. The patient reported for an Orthopedic evaluation with Dr. Haronian on February 18, 2013. Radiographs were performed. Medication for pain was prescribed and Physical therapy was recommended.

The patient has been certified today for a psychological consultation.

Current Work Status:
The patient is currently not working. He last worked on July 12, 2012.

Current Physical Complaints:

The patient complains of continuous aching in his right wrist, hand, and thumb, at times becoming sharp, shooting, and throbbing pain.

Current Psychological Complaints:
The patient endorsed the following symptoms: Forgetting things, anxious, unable to concentrate, agitated, lacking motivation, depressed, unable to enjoy activities, indecisive, feeling helpless, hopeless, moody, nauseated, losing things, restless, feeling tired, losing appetite, sleep disturbances, sexual problems and crying spells.

Background Information:
Mr. Doran was born in California in 1966. He was raised by his parents along with his 3 siblings. His father worked as attorney and his mother was a housewife. The patient has achieved a high school education. The patient denies behavioral, learning, or developmental problems in his upbringing. His parents are deceased. The patient denies exposure to trauma and abuse in his upbringing. The patient lived at home until the age of 18 at which point he moved out to be on his own. The patient has not had any prior marriages. The patient's first wife died 12 years ago. He has been dating a woman now for 5 years. They reside in the same home. The patient's girlfriend is retired. The patient has no children.

Occupational History:
The patient states that prior to working for Benedict & Benedict Plumbing, he was self-employed as a plumber. He has worked as a plumber for close to 30 years.

Legal History:
The patient has never been arrested. The patient has never been imprisoned.

The patient has never filed for bankruptcy.

The patient has never been involved in an act of domestic violence.

Illicit Drug/Tobacco/Alcohol Use History:
He does not drink and does not smoke. He denies a history of drug use.

Medical History:
The patient reports the following medical conditions: Diabetes.

Family Medical/Psychiatric History:
The patient denies a family history of psychiatric illness.

The patient is unaware of significant family medical conditions.

Prior Injuries:
The patient denies a history of prior injury.

Surgeries/Hospitalizations:
The patient denies a history of surgery/hospitalization.

Psychological History:
The patient denies a history of mental illness or treatment.

The patient denies a history of suicidal ideation/attempt. The patient has never been hospitalized for danger to self, or others or due to grave disability.

Mental Status:
The patient presented appearing the stated age. The patient presented with appropriate grooming and hygiene. He ambulated without the use of physical aid. The patient presents today appearing depressed. He has a pleasant way of relating to the evaluator. He speaks in a low and quiet tone. He cradles his right hand and wrist in the palm of his left hand. It appears to be pale in color. The patient's mood is depressed.

The patient related to the evaluator as candid and cooperative . He approached the evaluation process as open and responsive. He was alert.

Speech was a normal rate of responding and volume. Eye contact was normal. The patient showed no problems expressing self. He spoke fluently in English and without the use of an interpreter. He had no difficulty comprehending questions.

The patient demonstrated intact memory with no difficulty recalling personal events.

The patient was oriented to person, place, time, and situation.

The patient's responses were coherent and easy to understand. The patient's concentration and attention was adequate. The patient showed normal thought content. There was no presence of hallucinations or delusions. Judgment and insight were good.

The patient's intellectual ability was roughly average.

The expressed no suicidal or homicidal ideation. There is no apparent risk to self or others. The patient did no appear impulsive. Rapport was easily established.

Psychological Testing:
The following tests were assessed for their use in this evaluation based on recommendations by Medical Treatment Utilization Schedule (MTUS) of the American College of Occupational and Environmental Medicine (ACOEM Practice Guidelines) as well as other considerations. Other psychosocial instruments were selected based on their utility or relevance to a cognitive therapeutic approach. Tests are also included that assess concepts utilized within a stress-appraisal-coping model of pain based on the current psychosocial pain research literature and adapted from Lazarus and Folkman's (1984) transactional model of stress. These are tests that assess individual's beliefs, attitudes, cognitions and cognitive coping. An ideal test battery provides a road map for intervention and provides a method of tracking progress. These tests can be used as part of a pre-, ongoing, and post-treatment evaluation.

Beck Anxiety Inventory (BAI)

The Beck Anxiety Inventory is a 21-question self-report inventory, which asks the patient to choose from a hierarchy of levels of anxiety-related symptomatology for each question.

Client Score: 29
Interpretation: Moderate level of subjective anxiety.

Beck Depression Inventory (BDI)

The Beck Depression Inventory (BDI) has been widely used for the assessment of cognitions associated with depression for both psychiatric patients as well as depression in normals.

Client Score: 37
Interpretation: Severe level of subjective depression.

Pain Appraisal Inventory (PAI)

Developed by Unruh and Ritchie (1998), the PAI is designed to assess the primary appraisal process of people experiencing troubling pain. The scale is designed to assess if the person tends to appraise pain as a threat or a challenge. The PAI has been found to have good internal consistency (Chronbach's alpha: Threat Subscale = .86; Challenge = .81). The 16-item measure combines the primary appraisal categories of threat and harm/loss into one factor labeled the Threat/Loss scale and a second factor labeled the Challenge scale.

Threat/Loss Score: 4.00
Challenge Score: 1.00

Interpretation:
The high score on Threat/Loss suggests the patient may view any pain stimulus as a signal of danger and leading to avoidance. Exercise and other behavioral assignments may be viewed as having a high potential for causing reinjury or triggering a pain episode. The patient may judge that the pain has robbed him of all pleasurable aspects of life.

Survey of Pain Attitudes-Revised (SOPA-R)

The SOPA-R (Jenson, Turner, & Romano, 2000) is a well researched 35-item instrument that assesses patient feelings about pain control, solicitude (solicitous responses from others in response to one's pain), medication (as appropriate treatment for pain), pain-related harm (pain as an indicator of physical damage or harm). The instrument contains seven subscales (Solicitude, Medication, Medical Cure, Control, Disability, Emotion, and Harm).

Control: 4
The patient perceives low personal control over the pain. This perception predicts poorer overall adjustment to chronic pain. The score suggests a low level of self-efficacy or a belief by the patient that he cannot carry out certain coping options.

Emotion: 7

The patient does not understand that a relationship exists between emotions and pain. This reflects a lack of awareness that emotions have an impact on physical well being. This is a poorer prognostic sign.

Solicitude: 0
The patient does not believe that others should be solicitous in response to his pain. This is predictive of better psychological adjustment.

Medication: 7
The patient does not endorse the belief that medications in general are appropriate for chronic pain problems (e.g., "Medicine is one of the best treatments for chronic pain"). This is predictive of a fewer number of pain-related emergency room visits.

Medical Cure: 9
The patient does not endorse the belief that a medical cure exists for his pain problems.

Scores on Solicitude, Medication *or* Medical Cure scales provide information about *locus of control* (LOC).

Low scores on these scales, as seen with this patient, suggest internal (low external) LOC and typically accept control for pain rather than giving up control to a medical profession or significant other. Patient's with this pattern tend to report lower pain intensities, and less frequent pain than pain sufferers endorsing low internal (high external) LOC. Successful multidisciplinary treatment is associated with large decreases in patient's attribution of pain control to luck, fate, or the actions of others.

Disability: 16
The patient's responses suggest a belief that he is unable to function because of the pain. High scores suggest a belief that activity should be avoided because pain signifies damage and is associated with higher levels of physical disability. Such beliefs relates to passivity and avoidance of therapeutic activities.

Harm: 11
Low scores suggest a belief that activity should not necessarily be avoided because of pain and is associated with lower levels of physical disability. Such beliefs relates to greater adherence of therapeutic activities.

Pain Catastrophizing Scale (PCS)
Developed by Sullivan (1995) to measure pain catastrophizing and better understand the mechanism by which catastrophizing impacts the experience of pain. The PCS is reliable, valid, and robust in its prediction of pain and adaption to chronic pain. Negatively distorted pain-related cognitions involving magnification of the threat value of pain, rumination about pain, and perceived inability to control pain. The scale has 13 items with three subscales (Magnification, Rumination, Helplessness). A clinically relevant score is >38.

Client Total Score: 25

Interpretation:
The results are non-significant and suggests an adequate adjustment to chronic pain, decreased perceived disability, decreased occupational impairment, less emotional distress, and decreased medication use and use of healthcare services.

Coping Strategies Questionnaire-Revised (CSQ-R)
Revised CSQ 1997 (Riley and Robinson) of the original CSQ (Rosenstiel, 1983). The Coping Strategies Questionnaire (CSQ) uses a 27-item, 7-point rating scale to measures the frequency of use for common pain coping strategies. The CSQ is commonly used in pain studies and is appropriate for use in non-clinical and clinical populations. The scale has two general factors comprised of six scales. The Cognitive Coping Factor (Ignoring Pain, Praying, Distancing from the Pain, and Coping Self-Statements) is related to higher activity levels in patients with chronic pain. The Catastrophizing/Distraction Factor (Distraction and Catastrophizing) is related to poor indicators of adjustment to chronic pain.

Interpretation:
Results place the patient in the *low responder* subgroup indicating the patient scored low on all measures.

Pain Patient Profile (P-3)
The P-3 is a 44-item, self-report, multiple-choice instrument designed to identify patients who are experiencing emotional distress associated with primary complaints of pain. The P-3 is appropriate for patients suffering pain as a result of disease, illness, or physical trauma (e.g., motor vehicle accidents and work-related injuries). The P-3 has three clinical scales (Depression, Anxiety, and Somatization) and a Validity Index that assesses the probability of random responding, inadequate reading comprehension, and magnification of symptoms. Printed below are the patient's T scores.

	Depression	Anxiety	Somatization
T Score:	58	44	46

Validity Index: 10
(Valid) The patient's score on the Validity Index suggests that he was able to read the items and appropriately attended to item content. It appears that he approached the test in an open and honest manner. His score suggests that his test results can be interpreted with confidence.

Interpretation:
The Depression Scale: The patient's T score on the Depression scale
suggests the patient is more depressed than the typical pain patient.
Above-Average (55-71): Patients with scores above the average pain patient score on the Depression scale usually experience chronic fatigue, sadness, listlessness, and appetite and sleep disturbances associated with pain. The patient may have given up hope and may lack the motivation required for participating in a treatment program. (A psychological evaluation is strongly recommended for these patients.)

The Anxiety Scale: The patient's T score on the Anxiety scale is below average compared to the typical pain patient.
Below-Average (29-44): Scores below the average pain patient score on the Anxiety scale suggest adaptability, relaxation, self-confidence, and security. The patient may be experiencing an appropriate level of concern about the pain but remains generally optimistic and confident of improvement. Coping skills are generally intact, and there is little suggestion of undue cognitive distress or autonomic arousal.

The Somatization Scale: The patient's T score on the Somatization scale is in the average range compared to the typical pain patient.
Average (46-55): An average score on the Somatization scale suggests that the patient considers the somatic problems serious and feel somewhat threatened and vulnerable. However, the patient is usually not obsessed with the pain and physical problems. Somatic problems are of significant concern, and the patient is cognitively and emotionally distressed about the physical symptoms, but the patient is usually capable of participating fully in physical treatment for pain relief. Individuals with a clearly defined organic basis for pain often respond in this manner.

Review of Medical Records:
Secondary Physician Pain Management Initial Report, April 11, 2013, Dr. Kohan: A history of the injury is provided. There are complaints of pain to the right hand and thumb with numbness to the forearm. The patient has ongoing episodes of anxiety, stress and depression due to chronic pain and disability status. He has difficulty with sleep. He reports daytime fatigue and decreased concentration and memory at times. He worries about his medical condition and future. The review of system is provided. Impression: History of right hand contusion, sympathetically mediated neuropathic pain, right upper extremity possible mild CRPS, there are no definite signs of a diagnosis of CRPS. A triple phased bone scan will further elucidate the diagnosis.

Follow-up Report and Request for Authorization of a Primary Treating Physician, April 1, 2013, Dr. Haronian: Patient returns complaining of pain. The patient has been taking Neurontin which makes him "spacey". He will be weaned off Neurontin. He will begin Lexapro instead of Elavil as the patient did not like Elavil. The patient has evidence of depression. Psychotherapy has been authorized and he will be scheduled accordingly. There is increased suspicion of reflex sympathy dystrophy. Authorization is requested for a triple phase bone scan.

Follow-up Report of a Primary Treating Physician, March 18, 2013, Dr. Haronian: Patient returns complaining of chronic unremitting pain to the right hand and wrist. Authorization is pending for an MRI, pain management consultation and 4 sessions of psychotherapy. He tolerates the medication but is not receiving significant improvement. The patient will be started on Neurontin for neuropathic pain. He will be started on a trial of Elavil to help address insomnia, depression and pain. He will be tried on Vitamin C 500 mg.

There is a State Fund Utilization Review dated March 20, 2013: Several medical treatments were reviewed. Pertinent to this evaluation 4 sessions of psychotherapy as well as a psychological evaluation have been certified.

Conceptualization:

Mr. Doran presents today as a 46-year-old male who worked as a plumber for Benedict & Benedict. The patient suffered a work related injury July 11, 2012, when performing his duties a chunk of wood from above struck him on the right hand and wrist. He had immediate pain. He suffered a reported fracture to the right thumb with an open wound. The patient was placed in a hard cast. He has received physical therapy providing no benefit. He was noticing no improvement in his condition and sought legal counsel. He is currently under the care of Dr. Haronian. He is receiving medication. He was referred to Dr. Kohan, Pain Management, to look into the possible diagnosis of complex regional pain and dystrophy syndrome. He is pending a triple phase bone scan to further diagnose this condition. He has been prescribed Elavil providing no benefit. He was more recently started on Lexapro 10 mg. He appears to be taking it as prescribed but has no response so far. He has been referred today for a psychological consultation.

The patient presents with an unremarkable mental health history. He describes the onset of mood changes beginning around October and November of 2012. It was around that time that his orthopedic doctors at the time were advising him that his condition should have improved. However, his pain was only continuing. The pain continues to date. He has almost no use of the right hand. He has lost the mobility and strength. He experiences shooting pains that travel up the arm. He is right-hand dominant and his occupation requires the use of both hands to complete work. The patient has not responded well to medications. He took opioids by way of Norco for a short time. There was initial benefit but then that benefit waned so he stopped taking them. He experiences no relief from his current medication regiment.

Prior to the work injury the patient enjoyed an active lifestyle with his girlfriend of 5 years. On the day of the patient's injury he had just closed escrow on a mobile home. Even though the mobile home was in good condition he has been unable to do things to fix it up as he would normally have enjoyed. He used to enjoy fishing and going on weekend trips with his girlfriend. He has been unable to take part in these due to both the physical injury as well as the subsequent financial hardships that have developed. His girlfriend is retired.

The patient's mood on most days is described as depressed and with "low interest". He becomes restless and "fidgety" during the day thinking about his injury and his future. He indicates that he has become "disgusted" with himself because he is not healed. He has low motivation to engage in activities. Instead he "feels like a slug". His girlfriend remains supportive throughout the process. He tries to maintain some level of activity during the day but it is a struggle to get himself going. He watches television and reads magazines. He walks his dog at the park 2-3 times a day with his girlfriend. He has declined social invitations. Recently he was invited to attend the start of the trout season in Bishop. He normally would have enjoyed this but he turned his friends down indicating that he does not have the same interest in taking part in such activities. For a while he had become short-tempered and irritable as a result of the injuries. More recently he commented, "Now I just don't give a damn about things. I don't have concerns". He denies feeling hopeless stating that he needs to have some hope but otherwise feels that he is becoming increasing disinterested about things. He denies suicidal ideation.

The patient is especially concerned about his outlook and his future. He is uncertain as to what occupation he can be retrained into without the use of his dominant hand. The patient reports that at times he becomes so worried that he experiences symptoms consistent with anxiety. It is unclear if these symptoms meet criteria for discrete episodes of panic. The patient indicates that he will pay more close attention to the symptoms to further elucidate the diagnosis. At present he reports that about 2 days out of the week he experiences rapid heart rate, nausea, and a feeling that "everything around is moving very fast". Even the sounds feel like they are faster than normal. He is unable to characterize the symptoms well but states only that "it's just an upsetting feeling". He responds by "just trying to relax". He estimates that the symptoms last a few minutes at a time. The patient is drinking 2 cups of coffee in the morning to revive himself. This may be aggravating the anxiety symptoms.

Neurovegetative complaints are described by the patient. There are deficits of sleep onset and maintenance due to the combination of pain and nervousness. If he rolls over on his right side onto his hand there will be a shooting pain waking him. He has become better at positioning his right hand so that will not happen. Now he believes that he awakes more just because he is under so much stress. He never used to smoke at night but now finds himself getting out of bed to smoke a cigarette. He goes to bed at midnight and awakes at 2 o'clock in the morning. Once he falls back asleep he is up about every hour. He gets out of bed at 7:30 in the morning feeling lethargic but is unable to take naps during the day. The patient reports that he is more "foggy" and has difficulty focusing as a result. He has become forgetful especially of recent events. He misplaces items around the home with greater frequency. The patient's appetite has been low. He eats mostly because he knows he has to for his diabetic condition. He has his meal at night and a snack during the day that he takes with his medications. He estimates that he has lost about 7 pounds over the past 6 weeks. The patient has a chief concern of change to his libidinal drive. He is experiencing erectile dysfunction which began around December of last year.

Based on the available information the patient meets criteria for Depressive Disorder secondary to the workplace injury. I am concerned at this time that this could evolve into a major depressive episode. The patient also appears to report symptoms consistent with panic attacks though the patient will need to provide further information to the undersigned after he more closely monitors these symptoms. Should the patient develop a full blow panic disorder this would further aggravate the sympathetic nervous system creating greater pain and suffering. The patient has been authorized for evidenced based care. Authorization has been provided for 4 sessions of psychotherapy and he will be scheduled accordingly. The primary treating physician is also encouraged to consider making an adjustment to the dosage of his antidepressant medications. He is currently on Lexapro 10 mg. The patient could also certainly benefit from a psychiatric consultation to take over management of this medication.

DSM-IV-TR Diagnosis:

Axis I:	311	Depressive Disorder NOS.
	300	Anxiety Disorder NOS.
	780.52	Sleep Disorder Due To Pain, Insomnia Type.
	302.72	Male Erectile Disorder.
Axis II:	No Diagnosis	

Axis III: Deferred to appropriate medical specialist

Axis IV: Psychosocial and Environmental Problems: Chronic pain, disability status, ongoing need for medical attention, financial strain.

Axis V: GAF: 56 (Time of evaluation) 21% WPI

Causation:
Based on the available information, medical records, patient's report of the onset of symptoms and nature of the injury it is within reasonable probability that the psychological injury described above is the result of the work injury. The persistent pain, physical limitations and disability status are the predominate cause of the psychological injury described in today's evaluation. Any issues of apportionment will be discussed in detail once the patient has reached maximum medical improvement.

Work Restrictions:
Deferred to primary treating physician.

Recommendation:
Authorization has been provided for 4 sessions of psychotherapy and he will be scheduled accordingly. Patient will be administered intermittent diagnostic measures to assess change in his condition. The patient is recommended for a psychiatric consultation.

ODG Psychotherapy Guidelines:
Initial trial of 6 visits over 6 weeks
With evidence of objective functional improvement, total of up to 13-20 visits over 13-20 weeks (individual sessions)

Relevant Literature:
The following is based on Medical Treatment Utilization Schedule (MTUS) of the American College of Occupational and Environmental Medicine (ACOEM Practice Guidelines)

Psychological evaluations:
Recommended. Psychological evaluations are generally accepted, well-established diagnostic procedures not only with selected use in pain problems, but also with more widespread use in sub acute and chronic pain populations. Diagnostic evaluations should distinguish between conditions that are preexisting, aggravated by the current injury or work related. Psychosocial evaluations should determine if further psychosocial interventions are indicated. The interpretations of the evaluation should provide clinicians with a better understanding of the patient in their social environment, thus allowing for more effective rehabilitation. (Main-BMJ, 2002) (Gatchel, 1995) (Gatchel, 1999) (Gatchel, 2004) (Gatchel, 2005) For the evaluation and prediction of patients who have a high likelihood of developing chronic pain, a study of patients who were administered a standard battery psychological assessment test found that there is a psychosocial disability variable that is associated with those injured workers who are likely to develop chronic disability problems. (Gatchel, 1999) Childhood abuse and other past traumatic events were also found to be predictors of chronic pain patients. (Goldberg, 1999) Another trial found that it appears to be feasible to identify patients with high levels of risk of chronic pain and

to subsequently lower the risk for work disability by administering a cognitive-behavioral intervention focusing on psychological aspects of the pain problem. (Linton, 2002) Other studies and reviews support these theories. (Perez, 2001) (Pulliam, 2001) (Severeijns, 2001) (Sommer, 1998) In a large RCT the benefits of improved depression care (antidepressant medications and/or psychotherapy) extended beyond reduced depressive symptoms and included decreased pain as well as improved functional status. (Lin-JAMA, 2003)

Psychotherapy:
Recommended for appropriately identified patients during treatment for chronic pain. Psychological intervention for chronic pain includes setting goals, determining appropriateness of treatment, conceptualizing a patient's pain beliefs and coping styles, assessing psychological and cognitive function, and addressing co-morbid mood disorders (such as depression, anxiety, panic disorder, and posttraumatic stress disorder). Cognitive behavioral therapy and self-regulatory treatments have been found to be particularly effective. Psychological treatment incorporated into pain treatment has been found to have a positive short-term effect on pain interference and long-term effect on return to work.

I am aware of the following "stepped-care" approach to pain management that involves psychological intervention:

Step 1: Identify and address specific concerns about pain and enhance interventions that emphasize self management. The role of the psychologist at this point includes education and training of pain care providers in how to screen for patients that may need early psychological intervention.
Step 2: Identify patients who continue to experience pain and disability after the usual time of recovery. At this point a consultation with a psychologist allows for screening, assessment of goals, and further treatment options, including brief individual or group therapy.
Step 3: Pain is sustained in spite of continued therapy (including the above psychological care). Intensive care may be required from mental health professions allowing for a multidisciplinary treatment approach.

ODG –TWC *ODG Treatment Integrated Treatment/Disability Duration Guidelines*
Mental Illness & Stress
Cognitive behavior therapy for depression is recommended based on meta-analyses that compare its use with pharmaceuticals. Cognitive behavior therapy fared as well as antidepressant medication with severely depressed outpatients in four major comparisons. Effects may be longer lasting (80% relapse rate with antidepressants versus 25% with psychotherapy). (Paykel, 2006) (Bockting, 2006) (DeRubeis, 1999) (Goldapple, 2004) It also fared well in a meta-analysis comparing 78 clinical trials from 1977 -1996. (Gloaguen, 1998) In another study, it was found that combined therapy (antidepressant plus psychotherapy) was found to be more effective than psychotherapy alone. (Thase, 1997) A recent high quality study concluded that a substantial number of adequately treated patients did not respond to antidepressant therapy. (Corey-Lisle, 2004) A recent meta-analysis concluded that psychological treatment combined with antidepressant therapy is associated with a higher improvement rate than drug treatment alone. In longer therapies, the addition of psychotherapy helps to keep patients in treatment. (Pampallona, 2004) For panic disorder, cognitive behavior therapy is more effective and more cost-effective than medication. (Royal Australian, 2003) The gold standard for the evidence-based treatment of MDD is a combination of medication (antidepressants) and psychotherapy. The primary forms of psychotherapy that have been most studied through research are: Cognitive Behavioral Therapy and Interpersonal Therapy. (Warren, 2005)

A meta-analysis of the occupational stress-reducing interventions, including cognitive-behavioral interventions, relaxation techniques, multimodal programs, and organization-focused interventions, found that a small but significant overall effect was found. Cognitive-behavioral interventions were found to be the most effective, followed by multimodal interventions. (Van der Klink, 2001)

A multidisciplinary approach is the optimum type of intervention for pain and is an integral part of the work conditioning program and is consistent with the ACOEM Guidelines[1]. They include: interdiction of chronicity, interdiction of fear avoidance behavior (p. 91, 113)[1], interdiction of delayed recovery (p. 91, 362)[1], interdiction of somatization (p. 108)[1], decreased pain perception (p. 117)[1], decreasing depression and other maladaptive behaviors (pp. 108, 109, 114, 388, 400)[1]. The final goal is to build tolerance for intended activity, that is, the patient's return to full work duty (p. 315)[1]. This treatment is considered reasonable and necessary to treat the sequelae of his injury.

1 All page number references are to: Occupational Medicine Practice Guidelines: Evaluation and Management of Common Health Problems and Functional Recovery in Workers, Second Edition, edited by Lee S. Glass, M.D. Copyright © 2004 by The American College of Occupational and Environmental Medicine.

Subjects with chronic pain (defined as pain for most days for at least a month) are 3 times as likely to meet depression criteria as those without chronic pain.[3] The association between depression and pain becomes stronger as the severity of either condition increases. For example, as the severity of pain increases, depressive symptoms and depression diagnoses become more prevalent.[1, 2, 5] Likewise, as depression symptoms increase in severity, pain complaints are reported more often.[4]

1. Carroll LJ, Cassidy JD, Cote P. The Saskatchewan Health and Back Pain Survey: the prevalence and factors associated with depressive symptomatology in Saskatchewan adults. *Can J Public Health.*2000;91:459-464.
2. Lamb SE, Guralnik JM, Buchner DM, et al. Factors that modify the association between knee pain and mobility limitation in older women: the Women's Health and Aging Study. *Ann Rheum Dis.*2000;59:331-337.
3. Magni G, Marchetti M, Moreschi C, Merskey H, Luchini SR. Chronic musculoskeletal pain and depressive symptoms in the National Health and Nutrition Examination, I: epidemiologic follow-up study. *Pain.*1993;53:163-168.
4. Von Korff M, Dworkin SF, Le Resche L, Kruger A. An epidemiologic comparison of pain complaints. *Pain.*1988;32:173-183.
5. Moldin SO, Scheftner WA, Rice JP, Nelson E, Kneserich MA, Akiskal H. Association between major depressive disorder and physical illness. *Psychol Med.*1993;23:755-761.

Consistent with findings in primary care patients,[7] multiple pain complaints increase the probability of depression[8] such that patients with 2 or more different pain complaints are 6 times more likely to be depressed, and patients with 3 or more pain complaints are 8 times more likely to meet depression criteria.[6] In addition, more frequent pain episodes[9] and longer pain duration are associated with depression. An international study showed that patients with pain lasting longer than 6 months were more than 4 times as likely to have a depressive disorder as those without chronic pain.[10]

6. Katon W, Sullivan MD. Depression and chronic medical illness. *J Clin Psychiatry.*1990;51(suppl 6):3-11.
7. Kroenke K, Spitzer RL, Williams JB, et al. Physical symptoms in primary care: predictors of psychiatric disorders and functional impairment. *Arch Fam Med.*1994;3:774-779.
8. Dworkin RH, Gitlin MJ. Clinical aspects of depression in chronic pain patients. *Clin J Pain.*1991;7:79-94.
9. Wang SJ, Liu HC, Fuh JL, Liu CY, Wang PN, Lu SR. Comorbidity of headaches and depression in the elderly. *Pain.*1999;82:239-243.
10. Gureje O, Von Korff M, Simon GE, Gater R. Persistent pain and well-being: a World Health Organization Study in Primary Care. *JAMA.*1998;280:147-151. [erratum appears in *JAMA.* 1998;280:1142].

Disclosure:
The psychological tests are administered at this clinic. Instructions are included on the tests themselves and reviewed with the patient by the undersigned. All of the tests were interpreted by me. I reviewed any medical records set forth in the report. In addition to conducting the evaluation, I personally composed, drafted and edited the conclusions of this report.

I declare under the penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, as to information that I have indicated I received from others. As to that information, I declare under the penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe to be true.

A medical historian assisted with taking the history of the injury. I reviewed the history with the patient. I personally performed the clinical evaluation of the patient at
724 Corporate Center Dr, Pomona, CA 91768.

Except as otherwise stated herein, the evaluation was performed and the time spent performing the evaluation was in compliance with the guidelines, if any, established by the WC Medical Unit or the administrative director pursuant to paragraph (5) of subdivision (j) of Section 139.2 or Section 5370.6 of the California Labor Code. Pleased be advised that the itemization of the fees for this report is attached in a separate statement. Additional fees may be required for more extensive reports or more complex situations.

I further declare under the penalty of perjury that I have not violated the provisions of California Labor Code Section 139.3 with regard to the evaluation of this patient or preparation of this report.

Signed this 19th day of May of 2013, at Los Angeles County. Should any questions arise regarding this case, please do not hesitate to contact this office.

Sincerely,

Heath Hinze, Psy.D.
Clinical Psychologist
CA Lic.# PSY23840

CC: SCIF - LA (CLM# ENDING IN 00-49)
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