

### Identifying Data (Background Information)

Child's initials: F.A                      Age: 20 years                      Gender: Girl  
 Class: BS                                      Date seen: 29<sup>th</sup> October, 2014

### Source and Reason of Referral

The client was referred for the purpose of assessment and management of his current problems.

### Presenting Complaints

Table 1

*Presenting Complaints and Duration of the Child's Problems According to Client*

| <i>Presenting Complaints</i>              | <i>Duration</i> |
|---|-----------------|
| Low /sad mood                             |                 |
| Loss of interest                          |                 |
| Loss of pleasure                          |                 |
| Inability to cope with routine            |                 |
| Prominent anxiety                         |                 |
| Disturbance in sleeping and eating habits |                 |
| Talking about killing oneself or other    |                 |

### Description of presenting problem

In the next section of your case study, you will describe the problem or symptoms that the client presented with. Describe any physical, emotional, or sensory symptoms reported by the client. Thoughts, feelings, and perceptions related to the symptoms should also be noted. Any screening or diagnostic assessments that are used should also be described in detail and all scores reported.

F.A was 20 years old girl and studying in BS class. The child was neatly and properly dressed up as she was wearing clean and tidy clothes. In the first session, she established and maintained eye contact throughout the session but she was sitting at the chair, she seemed hesitating but after introduction of doctor she seemed comfortable. She was eager to share her problems with the doctor.

### Assessment

It was based at child's behavior observation for the purpose of to assess her posture and gesture which revealed her hygienic condition and her verbatim. Through observation nonverbal cues was also assessed. A structured clinical interview of the


child was taken to gather information about the history of child's presenting problem, background information and understanding of the problem for its management. Academic assessment conducted through formal method to find out his ability to comprehend his syllabus and familiarity with subject. It was also conducted to find out his problem regarding to studies and his strengths. Behavior assessment was carried out to understand underlining reasons of her \_\_\_\_\_ problems.

### **Hypotheses**

On the basis of above mentioned information following hypotheses could be generated

- It is hypothesized that child might have faced loss of **intrest** due to lack of exposure .
- It is hypothesized that child might have faced suicidal ideation due recent stressful life events experiences

### **Diagnosis**

Provide your diagnosis and Explain how you reached your diagnosis, how the client's symptoms fit the diagnostic criteria for the disorder(s), or any possible difficulties in reaching a diagnosis 

### **Differential Diagnosis**

**Management.** Different techniques was used according to the client's need for the purpose of management

- In order to manage \_\_\_\_\_ issues different techniques was used so that, she realizes that it is not an enjoyment but a torture at herself and others.
- Information care .
- Counseling
- Medication
- Life routin