charlie health

Your Request for Medical Records

Greetings,

The documentation you requested for a Charlie Health client is enclosed for your review.

Thank you,

John Nichols, RHIT - Release of Information Specialist
Charlie Health
medicalrecords@charliehealth.com

Note - These may contain incomplete (unsigned by provider) documents. If you need completed records please let us know by fax or email.

"This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient."

Our mailing address has changed. Please make note of the new mailing address and contact information below for your records. Thank you

California USA DRIVER LICENSE

DL B4945492

EXP 05/01/2028

LN MAHONEY

FN JOSEPH BERT

5025 THACHER RD

OJAI, CA 93023

DOB 05/01/1969

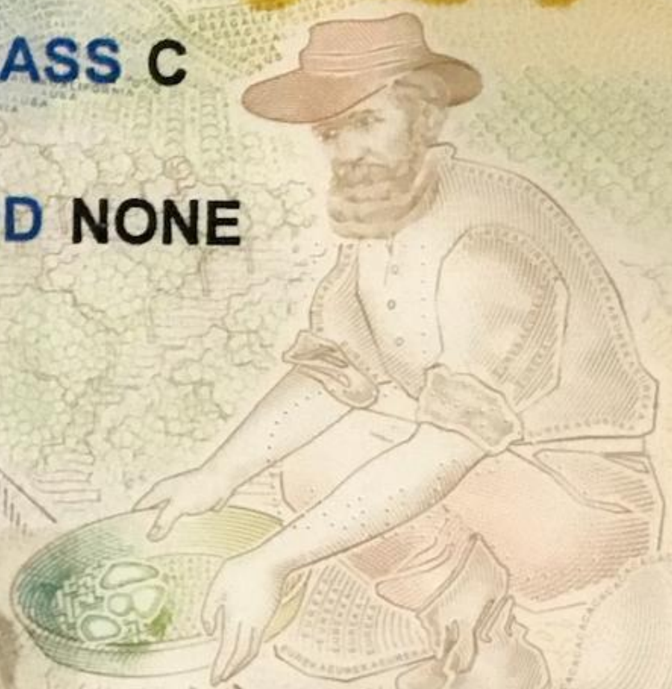
JM69

RSTR CORR LENS

DONOR

CLASS C

END NONE



05011969

SEX JM69 M HAIR GRY EYES BLU

HGT 5'-10" WGT 190 lb

DD 05/01/202363019/CCFD/28

JM69 ISS 05/01/2023

charlie health

233 E Main St. Suite 401
Bozeman, MT 59715
Office: (406) 840-0400 | Fax: (406) 720-7793

March 17, 2026

John Nichols

Re: Joseph Mahoney (DOB: 05/01/1969)

Subject: Release of Records

(No Message Body)

Sent by John Nichols on 03/17/2026 11:42 am in ElationHealth .

Interactive Patient Chart Contents:

- **Clinical Profile** *Allergies, Drug Intolerances, Problem List, History, Permanent Rx Meds, ...*
- **Patient Demographics** *Address, Insurance Info, etc.*
- **03/06/2026 Individual Note** *cc: Individual Therapy.*
- **02/27/2026 Individual Note** *cc: Individual Therapy.*
- **02/26/2026 Individual Note** *cc: Individual Therapy.*
- **02/20/2026 Individual Note** *cc: Individual Therapy.*
- **02/13/2026 Individual Note** *cc: Individual Therapy.*
- **02/06/2026 Individual Note** *cc: Individual Therapy.*
- **01/30/2026 Individual Note** *cc: Individual Therapy.*
- **01/23/2026 Individual Note** *cc: Individual Therapy.*
- **01/16/2026 Individual Note** *cc: Individual Therapy.*
- **01/09/2026 Individual Note** *cc: Individual Therapy.*
- **01/02/2026 Individual Note** *cc: Individual Therapy.*
- **12/26/2025 Individual Note** *cc: Individual Therapy.*

Replies not included

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Patient Demographic Information

As of 03/17/2026, in ElationHealth

Patient Name	Sex	Birthdate	SSN
Joseph Mahoney	M	05/01/1969	

Address

76 Second Street
Waterford, NY 12188

Contact Details

Cell Phone: 805-225-7061
Phone 2:
Email: berchman@mac.com

Primary Provider in Practice	Preferred Language	Preferred Method of Contact
No Assigned MD,	English	

Primary Insurance

Plan Name:
Group No.:
Member No.:

Notes

<<Contact>> First Name: Darrell Last Name: Ritchie Relationship: Other Phone Number: 3038752587 Email Address: fdrboulder@hotmail.com

Emergency Contact Name	Relationship
Darrell Ritchie	Other

Phone

3038752587

charlie health

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Bozeman, MT 59715
Office: (406) 840-0400 | Fax: (406) 720-7793

Clinical Profile

As of 03/17/2026, in ElationHealth

Patient Name: Joseph Mahoney

D.O.B.: 05/01/1969; 56 yrs, 10 mo at the time of printing this document
Sex at Birth: Male
Patient ID: 1138313849864193
Cared for by No Assigned MD,

Problem List

1. 2025 Major depressive disorder, recurrent severe without psychotic features
   Preliminary Primary
2. 2025 Anxiety disorder, unspecified
   Preliminary secondary

Past Medical History

- <<<EoC>>>
  Admission Date: 12/06/25
  Expected Discharge Date: 02/28/26
  Discharge Date: 02/27/26

Permanent Rx Medications

1. buPROPion ER (XL) 450 mg Tab ER 24hr Once daily (started on 01/05)
2. Venlafaxine ER 225 mg Tab ER 24hr 1x daily (started on 01/05)

Provider List

- Emma Stein, MA, Assoc Therapist (Primary Therapist)

Legal

- ROI - Amy Sullivan NP in Psychiatry reviewed on 12/05/2025
- ROI - Valera Health reviewed on 03/03/2026
- JBertMahoney-license-2025.JPG reviewed on 03/03/2026

charlie health

233 E Main St. Suite 401
Bozeman, MT 59715
Office: (406) 840-0400 | Fax: (406) 720-7793

Individual Note

ElationHealth

Patient Name: Joseph Mahoney

D.O.B.: 05/01/1969; 56 yrs, 10 mo at the time of visit
Seen by Emma Stein, LMSW, Associate Primary Therapist

Date of Encounter: 03/06/2026

Exam Reason (CC): Individual Therapy

Client did not attend session

REASON: No - Canceled

Reason for the cancelation:
Client discharged or is awaiting discharge

Additional details and/or attempts to contact client:
client discharged 2/28

Signed electronically by Emma Stein, LMSW, Associate Primary Therapist on 03/02/2026 7:52 am in ElationHealth

charlie health

233 E Main St. Suite 401
Bozeman, MT 59715
Office: (406) 840-0400 | Fax: (406) 720-7793

Individual Note

ElationHealth

Patient Name: Joseph Mahoney

D.O.B.: 05/01/1969; 56 yrs, 9 mo at the time of visit
Seen by Emma Stein, LMSW, Associate Primary Therapist

Date of Encounter: 02/27/2026

Exam Reason (CC): Individual Therapy

ATTENDANCE

Session type: Individual
Duration: 60mins (12:00 PM - 1:00 PM MT)

Client was present and seen via Zoom. Client confirmed to be in a confidential setting. Client confirmed identity.

SESSION OVERVIEW

PRESENTING SYMPTOM: The client is presenting in a significantly improved mental state as this is their final discharge session. They report no current acute symptoms and demonstrate strong emotional regulation and interpersonal functioning. Historically, the client experienced suicidal ideation during a previous period when they were living in their car, but this appears to be resolved. The client shows excellent insight, self-awareness, and has developed effective coping strategies using DBT skills. They report that DBT skills now naturally integrate into their daily life without conscious effort, particularly for managing interpersonal anxiety that previously caused panic-like responses.

DESCRIPTION OF SESSION: This final discharge session focused on celebrating the client's significant progress and planning for continued care. The client reflected extensively on their positive group therapy experience, describing how they naturally developed skills in active listening, making connections between concepts, and helping others through metaphors and insights. They discussed receiving powerful feedback from group members about their authentic presence and ability to help others gain clarity through reframing and questioning techniques. The session included a review of their MBC survey results, which showed dramatic improvement across all domains over the course of treatment. Dialectical Behavioral Therapy (DBT) skills were highlighted as particularly effective, with the client reporting that interpersonal effectiveness skills now automatically activate during challenging situations. The therapist and a discharge planner coordinated continued care through Valera, with the client scheduled to see Meredith Santoro, though this appointment was later cancelled and needs rescheduling. The client will continue psychiatric care with Amy Sullivan and has access to alumni groups following discharge.

CLIENT ASSESSMENT

Mental Status Exam was completed
- Observations
  - Appearance: Neat
  - Speech: Normal
  - Eye contact: Normal
  - Motor activity: Normal
  - Affect: Full
  - Comments: None
- Mood
  - Euthymic
  - Comments: None
- Cognition

• Orientation Impairment: None
• Memory Impairment: None
• Attention: Normal
• Comments: None
• Perception
• Hallucinations: None
• Other: None
• Comments: None
• Thoughts
• Suicidality: None
• Homicidality: None
• Delusions: None
• Comments: None
• Behavior
• Cooperative
• Comments: None
• Insight
• Good
• Comments: None
• Judgement
• Good
• Comments: None

MBC survey was last completed on 02/27/26 at 12:50 PM MT

PT reviewed client reported outcomes progress with client.

The client completed their first MBC Survey on 01/02/26. Their most recent MBC survey was completed on 02/27/26. WHO-5 overall scores have been 20, 44, 28, 56, 40, 48, 52, 60. Mental Health Functional Impairment (MHFI) scores have been School/Work: 2, N/A, N/A, N/A, N/A, N/A, N/A, N/A. Sleep: 1, 1, 2, 1, 1, 2, 2, 2. Brushing Teeth: 1, 1, 1, 1, 1, 1, 1, 1. Showering: 1, 1, 1, 1, 2, 1, 1, 2. Appetite: 2, 2, 1, 1, 1, 2, 2, 2. Medication: 2, 2, 2, 2, 2, 2, 2, 2. PROMIS Depression sum scores have been 23, 19, 26, 19, 23, 23, 17, 16. PROMIS Anxiety sum scores have been 17, 18, 17, 18, 18, 18, 10, 9.

Explanation of scores: WHO5: 5 questions each max score of 5, add the totals for each question (max 25) and then multiply the sum by 4 to get a percentage out of 100. Higher score indicates better wellbeing. Mental Health Functional Impairment (MHFI): 6 questions, each max score of 2. Higher scores indicate symptom improvement. Depression: 7 questions each max score of 5, add the totals for each question (max 35). Lower score indicates lower depression levels. Anxiety: 5 questions each max score of 5, add the totals for each question (max 25). Lower score indicates lower anxiety levels. N/A (Not Applicable) indicates that the client selected the N/A answer choice. N/R (Not Reported) indicates that the client did not select any answer choice.

Interpretation and Implications by PT: A MBC survey was completed. The client's scores showed significant improvement across multiple domains including psychological well-being, sleep troubles, and overall functioning, with a clear positive trend over the course of treatment.

TREATMENT PLAN OBJECTIVES

• Major depressive disorder, recurrent severe without psychotic features
• Decrease Frequent or recurrent thoughts of death, suicidal thoughts, suicide attempts or suicide from 4 per week to 1 per week in the next 8 week(s) as measured by Clinician observation

INTERVENTIONS:
• Anxiety disorder, unspecified
• DBT: Apply opposite action thinking and choose a response opposite from what your biological response activates you to do to increase emotional regulation.
• DBT: Practice radical acceptance to reduce internal conflict and increase distress tolerance.

SUMMARY: The client has successfully completed their intensive outpatient program and is ready for discharge to a lower level of care. DBT skills training has been highly effective, with the client reporting

natural integration of interpersonal effectiveness skills that previously required conscious effort. The treatment has successfully addressed their historical suicidal ideation and interpersonal anxiety, with measurable improvement shown across all assessment domains.

MEDICATIONS

Client reported taking medications as prescribed.

PLAN

Client will reschedule cancelled appointment with Meredith Santoro at Valera for continued therapy
Client will complete and return release of information forms to allow communication between current program and Valera
Client will continue psychiatric care with Amy Sullivan on Thursday at 9:30am
Client will have access to alumni groups starting approximately Wednesday after discharge paperwork is completed
Client will update discharge planner with new appointment details once rescheduled

SUBSTANCE USE

None

EATING-DISORDER BEHAVIORS

None reported

CLIENT SESSION SUMMARY

No session summary available - refer to clinical session notes

Signed electronically by Emma Stein, LMSW, Associate Primary Therapist on 02/27/2026 1:24 pm in ElationHealth

Co-signed electronically by Stephanie VanAlstyne, LCSW, Clinical Supervisor on 02/27/2026 2:24 pm

charlie health

233 E Main St. Suite 401
Bozeman, MT 59715
Office: (406) 840-0400 | Fax: (406) 720-7793

Individual Note

ElationHealth

Patient Name: Joseph Mahoney

D.O.B.: 05/01/1969; 56 yrs, 9 mo at the time of visit
Seen by Emma Stein, LMSW, Associate Primary Therapist

Date of Encounter: 02/26/2026

Exam Reason (CC): Individual Therapy

ATTENDANCE

Session type: Individual
Duration: 60mins (8:00 AM - 9:00 AM MT)

Client was present and seen via Zoom. Client confirmed to be in a confidential setting. Client confirmed identity.

SESSION OVERVIEW

PRESENTING SYMPTOM: The client is experiencing significant frustration and distress related to a perceived disconnect between their internal psychological progress and external life circumstances. They report feeling 'translucent' or invisible in social and professional settings, describing a sense of being unseen despite their readiness to re-engage with work and life. The client is experiencing ongoing job rejection and believes they are facing age-related discrimination in their job search efforts. They describe feeling impatient and having 'pent up energy' that wants to be released, using metaphors of being a racehorse trapped in a starting gate. These symptoms are impacting their ability to move forward professionally and are creating a cycle of invalidation that affects their self-perception and confidence in their recovery progress.

DESCRIPTION OF SESSION: The session began with the client describing technical difficulties accessing the therapy platform, which led to a discussion about user experience design and problem-solving approaches. The client reported positive experiences in group therapy, where they have taken on a mentoring role as the 'group elder' and are focused on making new members feel welcome. They discussed applying Dialectical Behavioral Therapy (DBT) skills, specifically mentioning 'opposite action' techniques that have helped them shift from a dark mental space to engaging in productive computer projects. The client shared their success in interpersonal situations where they were able to choose different responses rather than going on 'autopilot,' leading to positive reinforcement of these new behavioral patterns. The therapist explored the client's frustration with the disconnect between internal psychological progress and external validation, particularly regarding job search difficulties and perceived age discrimination. The session included discussion of transition planning as the program nears completion, with arrangements being made for continued therapeutic support.

CLIENT ASSESSMENT

Mental Status Exam was completed
- Observations
  - Appearance: Neat
  - Speech: Normal
  - Eye contact: Normal
  - Motor activity: Normal
  - Affect: Full
  - Comments: None
- Mood
  - Euthymic

• Comments: None
• Cognition
• Orientation Impairment: None
• Memory Impairment: None
• Attention: Normal
• Comments: None
• Perception
• Hallucinations: None
• Other: None
• Comments: None
• Thoughts
• Suicidality: None
• Homicidality: None
• Delusions: None
• Comments: None
• Behavior
• Cooperative
• Comments: None
• Insight
• Good
• Comments: None
• Judgement
• Good
• Comments: None

MBC survey was last completed on 02/13/26 at 12:54 PM MT

The client completed their first MBC Survey on 01/02/26. Their most recent MBC survey was completed on 02/13/26. WHO-5 overall scores have been 20, 44, 28, 56, 40, 48, 52. Mental Health Functional Impairment (MHFI) scores have been School/Work: 2, N/A, N/A, N/A, N/A, N/A, N/A. Sleep: 1, 1, 2, 1, 1, 2, 2. Brushing Teeth: 1, 1, 1, 1, 1, 1, 1. Showering: 1, 1, 1, 1, 2, 1, 1. Appetite: 2, 2, 1, 1, 1, 2, 2. Medication: 2, 2, 2, 2, 2, 2, 2. PROMIS Depression sum scores have been 23, 19, 26, 19, 23, 23, 17. PROMIS Anxiety sum scores have been 17, 18, 17, 18, 18, 18, 10.

Explanation of scores: WHO5: 5 questions each max score of 5, add the totals for each question (max 25) and then multiply the sum by 4 to get a percentage out of 100. Higher score indicates better wellbeing. Mental Health Functional Impairment (MHFI): 6 questions, each max score of 2. Higher scores indicate symptom improvement. Depression: 7 questions each max score of 5, add the totals for each question (max 35). Lower score indicates lower depression levels. Anxiety: 5 questions each max score of 5, add the totals for each question (max 25). Lower score indicates lower anxiety levels. N/A (Not Applicable) indicates that the client selected the N/A answer choice. N/R (Not Reported) indicates that the client did not select any answer choice.

Interpretation and Implications by PT: Therapist will send the survey tomorrow

TREATMENT PLAN OBJECTIVES

• Major depressive disorder, recurrent severe without psychotic features
• Decrease Frequent or recurrent thoughts of death, suicidal thoughts, suicide attempts or suicide from 4 per week to 1 per week in the next 8 week(s) as measured by Clinician observation

INTERVENTIONS:
• Anxiety disorder, unspecified
• DBT: Develop and establish healthy, flexible boundaries to promote improve interpersonal effectiveness in relationships.
• DBT: Apply opposite action thinking and choose a response opposite from what your biological response activates you to do to increase emotional regulation.

SUMMARY: The client is making substantial progress in applying DBT skills, particularly opposite action techniques and interpersonal effectiveness strategies. They report successful implementation of these skills in real-world situations, leading to positive behavioral changes and increased confidence. The

therapeutic work is effectively addressing their tendency toward negative thought patterns and self-criticism, with the client now able to recognize and counter these patterns more consistently.

MEDICATIONS

Client reported taking medications as prescribed.

PLAN

Client will contact Key regarding transition planning and setting up continued therapeutic support
Client will continue attending group therapy sessions
Client will request access to therapy session notes by emailing medical records at Charlie Health
Transition coordinator will join the final session to ensure continuity of care

SUBSTANCE USE

None

EATING-DISORDER BEHAVIORS

None reported

CLIENT SESSION SUMMARY

No session summary available - refer to clinical session notes

Signed electronically by Emma Stein, LMSW, Associate Primary Therapist on 02/26/2026 10:55 am in ElationHealth

Co-signed electronically by Stephanie VanAlstyne, LCSW, Clinical Supervisor on 02/27/2026 1:44 pm

charlie health

233 E Main St. Suite 401
Bozeman, MT 59715
Office: (406) 840-0400 | Fax: (406) 720-7793

Individual Note

ElationHealth

Patient Name: Joseph Mahoney

D.O.B.: 05/01/1969; 56 yrs, 9 mo at the time of visit
Seen by Emma Stein, LMSW, Associate Primary Therapist

Date of Encounter: 02/20/2026

Exam Reason (CC): Individual Therapy

Client did not attend session

REASON: No - Canceled

Reason for the cancelation:
Clinician is on vacation

Additional details and/or attempts to contact client:
Clinician is on vacation

Signed electronically by Emma Stein, LMSW, Associate Primary Therapist on 02/13/2026 2:57 pm in ElationHealth

charlie health

233 E Main St. Suite 401
Bozeman, MT 59715
Office: (406) 840-0400 | Fax: (406) 720-7793

Individual Note

ElationHealth

Patient Name: Joseph Mahoney

D.O.B.: 05/01/1969; 56 yrs, 9 mo at the time of visit
Seen by Emma Stein, LMSW, Associate Primary Therapist

Date of Encounter: 02/13/2026

Exam Reason (CC): Individual Therapy

ATTENDANCE

Session type: Individual
Duration: 60mins (12:00 PM - 1:00 PM MT)

Client was present and seen via Zoom. Client confirmed to be in a confidential setting. Client confirmed identity.

SESSION OVERVIEW

PRESENTING SYMPTOM: The client is demonstrating significant improvement in emotional regulation and interpersonal functioning as they approach discharge from their intensive outpatient program. They report feeling notably more grounded, centered, and emotionally stable, particularly in interactions with their father who has historically been a major trigger for dysregulation. The client describes experiencing a sense of embodiment and self-confidence that feels foreign but stable, contrasting sharply with their previous patterns of emotional reactivity and hypervigilance. They are successfully applying Dialectical Behavioral Therapy (DBT) skills in real-world situations, including opposite action techniques and distress tolerance skills. The client reports improved sleep patterns, better recognition of their body's need for rest, and decreased anxiety about upcoming transitions, including the end of their treatment program.

DESCRIPTION OF SESSION: The session began with the client requesting access to session transcripts to review insights that crystallize during therapy conversations, demonstrating their commitment to integrating therapeutic gains. The client provided updates on their group therapy experience, including the graduation of a long-term group member and their emerging role as a senior member. Significant discussion centered on the client's remarkable progress in emotional regulation, particularly in interactions with their father who has been a primary trigger throughout their life. The client described feeling grounded and centered rather than dysregulated, noting their father's shift from judgmental questioning to genuine curiosity. The therapist and client explored concepts of embodiment and self-energy, with the client recognizing a fundamental shift from seeing themselves as 'the problem' to developing genuine self-worth and confidence. The session incorporated Dialectical Behavioral Therapy (DBT) principles, particularly opposite action and distress tolerance skills. The client demonstrated sophisticated insight into their nervous system regulation, distinguishing between emotional and physiological arousal and successfully implementing breathing techniques and meditation for self-regulation. The conversation highlighted the client's integration of therapeutic concepts through consistent engagement with group therapy, note-taking, and reflection practices.

CLIENT ASSESSMENT

Mental Status Exam was completed
• Observations
 • Appearance: Neat
 • Speech: Normal
 • Eye contact: Normal
 • Motor activity: Normal
 • Affect: Full

• Comments: None
• Mood
• Anxious; Depressed
• Comments: None
• Cognition
• Orientation Impairment: None
• Memory Impairment: None
• Attention: Normal
• Comments: None
• Perception
• Hallucinations: None
• Other: None
• Comments: None
• Thoughts
• Suicidality: None
• Homicidality: None
• Delusions: None
• Comments: None
• Behavior
• Cooperative
• Comments: None
• Insight
• Good
• Comments: None
• Judgement
• Good
• Comments: None

MBC survey was last completed on 02/13/26 at 12:54 PM MT

PT reviewed client reported outcomes progress with client.

The client completed their first MBC Survey on 01/02/26. Their most recent MBC survey was completed on 02/13/26. WHO-5 overall scores have been 20, 44, 28, 56, 40, 48, 52. Mental Health Functional Impairment (MHFI) scores have been School/Work: 2, N/A, N/A, N/A, N/A, N/A, N/A. Sleep: 1, 1, 2, 1, 1, 2, 2. Brushing Teeth: 1, 1, 1, 1, 1, 1, 1. Showering: 1, 1, 1, 1, 2, 1, 1. Appetite: 2, 2, 1, 1, 1, 2, 2. Medication: 2, 2, 2, 2, 2, 2, 2. PROMIS Depression sum scores have been 23, 19, 26, 19, 23, 23, 17. PROMIS Anxiety sum scores have been 17, 18, 17, 18, 18, 18, 10.

Explanation of scores: WHO5: 5 questions each max score of 5, add the totals for each question (max 25) and then multiply the sum by 4 to get a percentage out of 100. Higher score indicates better wellbeing. Mental Health Functional Impairment (MHFI): 6 questions, each max score of 2. Higher scores indicate symptom improvement. Depression: 7 questions each max score of 5, add the totals for each question (max 35). Lower score indicates lower depression levels. Anxiety: 5 questions each max score of 5, add the totals for each question (max 25). Lower score indicates lower anxiety levels. N/A (Not Applicable) indicates that the client selected the N/A answer choice. N/R (Not Reported) indicates that the client did not select any answer choice.

Interpretation and Implications by PT: Clients MBC measures indicate a steady improvement in the clients mental health symptoms. Client reports that this is due to implementing DBT skills into every day life. Therapist and client will continue to implement DBT skills in order to continue to improve measures.

TREATMENT PLAN OBJECTIVES

• Anxiety disorder, unspecified
• Decrease Sense of impending doom or danger from 7 per week to 4 per week in the next 8 week(s) as measured by Clinician observation
• Major depressive disorder, recurrent severe without psychotic features
• Decrease Frequent or recurrent thoughts of death, suicidal thoughts, suicide attempts or suicide from 4 per week to 1 per week in the next 8 week(s) as measured by Clinician observation

INTERVENTIONS:
• Anxiety disorder, unspecified
• Psychoeducation: Combine the elements of cognitive behavior therapy, group therapy, and education to provide the client and family knowledge about symptoms, diagnosis, and treatment to improve collaboration with mental health professionals for a better overall outcome.
• DBT: Practice coping ahead to rehearse plans ahead of time and practice coping skills to increase emotional regulation.

SUMMARY: The client is making excellent progress toward treatment goals through consistent application of DBT skills, particularly emotional regulation and distress tolerance techniques. Their ability to remain grounded during historically triggering interactions with their father demonstrates significant advancement in interpersonal effectiveness skills. The client's integration of therapeutic concepts through group participation, self-reflection, and real-world application indicates strong treatment engagement and sustainable progress toward discharge goals.

MEDICATIONS

Client reported taking medications as prescribed.
PLAN

Continue attending group therapy sessions 3x per week
Continue practicing DBT skills, particularly grounding techniques and emotional regulation strategies
Continue self-reflection and note-taking practices after group sessions
The therapist will be out next week, so the client will meet twice the following week: Monday the 23rd at 9am and Friday the 27th at 2pm
Friday the 27th will be the final session before discharge

SUBSTANCE USE

None

EATING-DISORDER BEHAVIORS

None reported

CLIENT SESSION SUMMARY

No session summary available - refer to clinical session notes

Signed electronically by Emma Stein, LMSW, Associate Primary Therapist on 02/13/2026 3:07 pm in ElationHealth

Co-signed electronically by Stephanie VanAlstyne, LCSW, Clinical Supervisor on 02/19/2026 2:37 pm

charlie health

233 E Main St. Suite 401
Bozeman, MT 59715
Office: (406) 840-0400 | Fax: (406) 720-7793

Individual Note

ElationHealth

Patient Name: Joseph Mahoney

D.O.B.: 05/01/1969; 56 yrs, 9 mo at the time of visit
Seen by Emma Stein, LMSW, Associate Primary Therapist

Date of Encounter: 02/06/2026

Exam Reason (CC): Individual Therapy

ATTENDANCE

Session type: Individual
Duration: 60mins (12:00 PM - 1:00 PM MT)

Client was present and seen via Zoom. Client confirmed to be in a confidential setting. Client confirmed identity.

SESSION OVERVIEW

PRESENTING SYMPTOM: The client is presenting with depression and is currently enrolled in an intensive therapy program. They report experiencing dissociation, which they describe as feeling like they are watching their life like a TV show, similar to the movie "Being John Malkovich." The client exhibits hypervigilance and avoidance behaviors that stem from childhood, including a pattern of avoiding people and situations. They experience significant triggers related to interactions with their father, which historically cause visceral emotional and physical reactions, dysregulation, and difficulty communicating clearly. These symptoms have impacted their ability to maintain employment and have left their "outer world" feeling frozen in time, despite feeling they are making mental health progress.

DESCRIPTION OF SESSION: The client discussed their experiences in group therapy over the past week, including a particularly challenging Tuesday session where they participated minimally and felt frustrated. They explored the source of their frustration, identifying a disconnect between their internal progress and their external circumstances remaining stagnant. The client reported a significant breakthrough when interacting with their father, where for the first time in their life, they did not experience their typical trigger response to his questioning about job searching. Instead, they remained calm and were able to use skills to respond effectively, representing successful application of Dialectical Behavioral Therapy (DBT) techniques, particularly opposite action. The session focused on the client's increased ability to recall and implement therapeutic tools in real-time situations, which they attribute to the intensive nature of their current treatment program. The client also discussed their continued work on a Substack writing project, which they believe contributes to their therapeutic processing. The therapist explored what factors contributed to this significant shift in the client's response patterns, with the client identifying the intensive group therapy format and repeated exposure to DBT skills as key elements in their progress.

CLIENT ASSESSMENT

Mental Status Exam was completed
- Observations
  - Appearance: Neat
  - Speech: Normal
  - Eye contact: Normal
  - Motor activity: Normal
  - Affect: Full
  - Comments: None
- Mood
  - Euthymic

• Comments: None
• Cognition
• Orientation Impairment: None
• Memory Impairment: None
• Attention: Normal
• Comments: None
• Perception
• Hallucinations: None
• Other: None
• Comments: None
• Thoughts
• Suicidality: None
• Homicidality: None
• Delusions: None
• Comments: None
• Behavior
• Cooperative
• Comments: None
• Insight
• Good
• Comments: None
• Judgement
• Good
• Comments: None

MBC survey was last completed on 02/06/26 at 12:59 PM MT

PT reviewed client reported outcomes progress with client.

The client completed their first MBC Survey on 01/02/26. Their most recent MBC survey was completed on 02/06/26. WHO-5 overall scores have been 20, 44, 28, 56, 40, 48. Mental Health Functional Impairment (MHFI) scores have been School/Work: 2, N/A, N/A, N/A, N/A, N/A. Sleep: 1, 1, 2, 1, 1, 2. Brushing Teeth: 1, 1, 1, 1, 1, 1. Showering: 1, 1, 1, 1, 2, 1. Appetite: 2, 2, 1, 1, 1, 2. Medication: 2, 2, 2, 2, 2, 2. PROMIS Depression sum scores have been 23, 19, 26, 19, 23, 23. PROMIS Anxiety sum scores have been 17, 18, 17, 18, 18, 18.

Explanation of scores: WHO5: 5 questions each max score of 5, add the totals for each question (max 25) and then multiply the sum by 4 to get a percentage out of 100. Higher score indicates better wellbeing. Mental Health Functional Impairment (MHFI): 6 questions, each max score of 2. Higher scores indicate symptom improvement. Depression: 7 questions each max score of 5, add the totals for each question (max 35). Lower score indicates lower depression levels. Anxiety: 5 questions each max score of 5, add the totals for each question (max 25). Lower score indicates lower anxiety levels. N/A (Not Applicable) indicates that the client selected the N/A answer choice. N/R (Not Reported) indicates that the client did not select any answer choice.

Interpretation and Implications by PT: Clients MBC measures indicate an improvement in the clients mental health symptoms. Client reports that going through the program at CH he has noticed a difference in his ability to cope with life stressors. Client wants to continue to use DBT skills in order to continue to improve MBC measures.

TREATMENT PLAN OBJECTIVES

• Major depressive disorder, recurrent severe without psychotic features
• Decrease Frequent or recurrent thoughts of death, suicidal thoughts, suicide attempts or suicide from 4 per week to 1 per week in the next 8 week(s) as measured by Clinician observation

INTERVENTIONS:
• Anxiety disorder, unspecified
• DBT: Apply opposite action thinking and choose a response opposite from what your biological response activates you to do to increase emotional regulation.
• DBT: Develop and establish healthy, flexible boundaries to promote improve interpersonal effectiveness

in relationships.

SUMMARY: The client is making significant progress in applying DBT skills, particularly opposite action, in real-life situations. The intensive group therapy format is proving effective in helping them internalize and recall therapeutic tools when needed. Their breakthrough interaction with their father represents a major milestone in emotional regulation and demonstrates successful integration of therapeutic interventions into daily functioning.

MEDICATIONS

Client reported taking medications as prescribed.
PLAN

Continue to notice moments where there wasn't an automatic reaction and things felt different
Observe and reflect on instances where integration of skills is happening
Notice situations where triggers were challenged and compare/contrast with past reactions
Continue attending group therapy sessions 3x per week
Complete the survey that will be sent by the therapist

SUBSTANCE USE

None

EATING-DISORDER BEHAVIORS

None reported

CLIENT SESSION SUMMARY

No session summary available - refer to clinical session notes

Signed electronically by Emma Stein, LMSW, Associate Primary Therapist on 02/06/2026 1:49 pm in ElationHealth

Co-signed electronically by Stephanie VanAlstyne, LCSW, Clinical Supervisor on 02/11/2026 9:38 am

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Individual Note

ElationHealth

Patient Name: Joseph Mahoney

D.O.B.: 05/01/1969; 56 yrs, 8 mo at the time of visit
Seen by Emma Stein, LMSW, Associate Primary Therapist

Date of Encounter: 01/30/2026

Exam Reason (CC): Individual Therapy

ATTENDANCE

Session type: Individual
Duration: 60mins (12:00 PM - 1:00 PM MT)

Client was present and seen via Zoom. Client confirmed to be in a confidential setting. Client confirmed identity.

SESSION OVERVIEW

PRESENTING SYMPTOM: The client is presenting with symptoms of depression, including periods of falling into what they describe as a dark hole of negative self-perception, though they report this has been less frequent over the past two weeks. The client experiences significant physical manifestations of stress and trauma, including severe tension headaches from teeth grinding, shoulder and neck tension requiring use of massage tools for relief. Emotionally, the client reports intense cathartic episodes when processing trauma through writing exercises, including visceral crying, heaving, and hands-on-knees physical responses. The client describes chronic mental and physical exhaustion from intensive therapeutic work, and reports a history of dissociation as a coping mechanism that has manifested in various ways throughout their life. These symptoms are impacting the client's daily functioning by causing significant fatigue, though notably the client is maintaining engagement in therapeutic activities and demonstrating improved ability to practice self-care rather than falling into depressive patterns when exhausted.

DESCRIPTION OF SESSION: The client and therapist discussed significant progress the client has experienced over the past two weeks in developing awareness and catching negative thought patterns closer to the moment they occur. The client reported intensive participation in group therapy three times weekly and described how hearing others' experiences has facilitated important connections and insights. A major focus was the client's work on Substack writing prompts that involve revisiting traumatic memories, which has triggered intense emotional releases including crying and physical responses. The therapist and client explored the concept of protective mechanisms and how the client has been subconsciously avoiding painful memories due to their overwhelming nature, with reference to concepts from The Body Keeps the Score regarding somatic trauma storage. The client discussed their understanding of dissociation as a survival mechanism that has evolved throughout their life from childhood daydreaming to more concerning episodes of lost time. A significant breakthrough was explored regarding a recent conflict with the client's mother where the client chose self-advocacy over their typical pattern of people-pleasing and emotional caretaking of others. The therapist provided psychoeducation about neural pathways and how practicing new responses creates new patterns in the brain. The client demonstrated insight into how childhood experiences of invalidation and being told to suppress emotions contributed to current patterns of stuffing feelings down. The session highlighted the client's recognition that they have historically prioritized others' emotional needs over their own across all relationships, and their recent choice to speak up for themselves represents a foundational shift. The client also mentioned requesting continuation of group therapy to align with their individual therapy timeline.

CLIENT ASSESSMENT

Mental Status Exam was completed

• Observations
 • Appearance: Neat
 • Speech: Normal
 • Eye contact: Normal
 • Motor activity: Normal
 • Affect: Full
 • Comments: None
• Mood
 • Depressed
 • Comments: None
• Cognition
 • Orientation Impairment: None
 • Memory Impairment: None
 • Attention: Normal
 • Comments: None
• Perception
 • Hallucinations: None
 • Other: None
 • Comments: None
• Thoughts
 • Suicidality: None
 • Homicidality: None
 • Delusions: None
 • Comments: None
• Behavior
 • Cooperative
 • Comments: None
• Insight
 • Good
 • Comments: None
• Judgement
 • Good
 • Comments: None

MBC survey was last completed on 01/30/26 at 12:56 PM MT

PT reviewed client reported outcomes progress with client.

The client completed their first MBC Survey on 01/02/26. Their most recent MBC survey was completed on 01/30/26. WHO-5 overall scores have been 20, 44, 28, 56, 40. Mental Health Functional Impairment (MHFI) scores have been School/Work: 2, N/A, N/A, N/A, N/A. Sleep: 1, 1, 2, 1, 1. Brushing Teeth: 1, 1, 1, 1, 1. Showering: 1, 1, 1, 1, 2. Appetite: 2, 2, 1, 1, 1. Medication: 2, 2, 2, 2, 2. PROMIS Depression sum scores have been 23, 19, 26, 19, 23. PROMIS Anxiety sum scores have been 17, 18, 17, 18, 18.

Explanation of scores: WHO5: 5 questions each max score of 5, add the totals for each question (max 25) and then multiply the sum by 4 to get a percentage out of 100. Higher score indicates better wellbeing. Mental Health Functional Impairment (MHFI): 6 questions, each max score of 2. Higher scores indicate symptom improvement. Depression: 7 questions each max score of 5, add the totals for each question (max 35). Lower score indicates lower depression levels. Anxiety: 5 questions each max score of 5, add the totals for each question (max 25). Lower score indicates lower anxiety levels. N/A (Not Applicable) indicates that the client selected the N/A answer choice. N/R (Not Reported) indicates that the client did not select any answer choice.

Interpretation and Implications by PT: Clients MBC measures indicate that the clients mental health needs improving. Client reports that this week has been intense in processing some of the previous experiences that hes had. Therapist and client will continue to process in order to improve clients MBC measures.

TREATMENT PLAN OBJECTIVES

• Major depressive disorder, recurrent severe without psychotic features
 • Decrease Frequent or recurrent thoughts of death, suicidal thoughts, suicide attempts or suicide from 4

per week to 1 per week in the next 8 week(s) as measured by Clinician observation
• Anxiety disorder, unspecified
• Decrease Sense of impending doom or danger from 7 per week to 4 per week in the next 8 week(s) as measured by Clinician observation

INTERVENTIONS:
• Anxiety disorder, unspecified
• DBT: Practice mindfulness through non-judgment, focusing awareness on the present moment, and being effective.
• Group Sessions: Client will share openly in group about their day.
• Group Sessions: Learn skills in group setting.
• Group Sessions: Attend 3 hours of groups 3 days a week.

SUMMARY: The client is making substantial progress in trauma processing through writing exercises and group therapy participation, which are facilitating emotional release and insight development. The therapeutic work is targeting avoidance patterns and helping the client access previously protected emotions, which appears to be reducing shame and increasing self-awareness. A notable breakthrough occurred in practicing assertiveness and self-advocacy rather than defaulting to people-pleasing behaviors, suggesting development of healthier relational patterns and boundary-setting skills that represent new neural pathways being formed.

MEDICATIONS

Client reported taking medications as prescribed.
PLAN

Continue practicing awareness of moments when choosing self-advocacy over people-pleasing in interpersonal interactions
Monitor and report back on instances of choosing to recognize own emotions first, particularly when feeling invalidated
Continue participation in group therapy three times weekly (client has requested extension to align with individual therapy timeline)
Continue self-care practices when experiencing physical symptoms of stress
Client confirmed they will attend next session at regular time

SUBSTANCE USE

None

EATING-DISORDER BEHAVIORS

None reported

CLIENT SESSION SUMMARY

No session summary available - refer to clinical session notes

Signed electronically by Emma Stein, LMSW, Associate Primary Therapist on 01/30/2026 1:42 pm in ElationHealth

Co-signed electronically by Stephanie VanAlstyne, LCSW, Clinical Supervisor on 02/01/2026 4:41 pm

charlie health

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Individual Note

ElationHealth

Patient Name: Joseph Mahoney

D.O.B.: 05/01/1969; 56 yrs, 8 mo at the time of visit
Seen by Emma Stein, LMSW, Associate Primary Therapist

Date of Encounter: 01/23/2026

Exam Reason (CC): Individual Therapy

ATTENDANCE

Session type: Individual
Duration: 60mins (12:00 PM - 1:00 PM MT)

Client was present and seen via Zoom. Client confirmed to be in a confidential setting. Client confirmed identity.

SESSION OVERVIEW

PRESENTING SYMPTOM: The client is presenting with persistent depression and deeply ingrained feelings of inadequacy that have been present for approximately three years. They describe experiencing an internalized critical voice, which they identify as their father's punitive voice, that manifests as self-denial behaviors and thoughts of not deserving good things. The client reports having lived in their car during a particularly severe depressive episode and describes periods where they felt they deserved to suffer, using the visceral imagery of Japanese hari kiri to describe the emotional pain. These symptoms significantly impact their functioning through self-sabotaging behaviors, difficulty with self-care, and a pattern of putting others' needs before their own to prove their worth, which ultimately led to the severe depression that resulted in homelessness.

DESCRIPTION OF SESSION: The client and therapist explored the connection between childhood experiences and current self-defeating thought patterns. The client shared positive engagement with personal projects including writing on Substack, developing a Chrome extension for YouTube playlist management, and creating an AI voice clone, which represented a significant shift from their typical daily experience over the past three years. Building on homework from the previous session about their "shadow self," the client examined repressed anger and punitive internal dialogue. The session focused extensively on childhood memories of being repeatedly told "no" when asking for things at the store, which the client connected to developing beliefs about not deserving good things. Through therapeutic exploration, the client was able to reframe these childhood experiences, recognizing that their parents' refusals were likely due to financial constraints rather than the client's worthiness. The therapist helped the client identify how these early experiences created neural pathways that continue to trigger automatic responses of self-denial and self-punishment. The session incorporated elements of psychoeducation about neural pathways and trauma responses, while the therapist proposed future work with inner child healing to address the core belief of not being good enough.

CLIENT ASSESSMENT

Mental Status Exam was completed
- Observations
- Appearance: Neat
- Speech: Normal
- Eye contact: Normal
- Motor activity: Normal
- Affect: Full
- Comments: None

• Mood
 • Anxious; Depressed
 • Comments: None
• Cognition
 • Orientation Impairment: None
 • Memory Impairment: None
 • Attention: Normal
 • Comments: None
• Perception
 • Hallucinations: None
 • Other: None
 • Comments: None
• Thoughts
 • Suicidality: None
 • Homicidality: None
 • Delusions: None
 • Comments: None
• Behavior
 • Cooperative
 • Comments: None
• Insight
 • Good
 • Comments: None
• Judgement
 • Good
 • Comments: None

MBC survey was last completed on 01/23/26 at 12:57 PM MT

PT reviewed client reported outcomes progress with client.

The client completed their first MBC Survey on 01/02/26. Their most recent MBC survey was completed on 01/23/26. WHO-5 overall scores have been 20, 44, 28, 56. Mental Health Functional Impairment (MHFI) scores have been School/Work: 2, N/A, N/A, N/A. Sleep: 1, 1, 2, 1. Brushing Teeth: 1, 1, 1, 1. Showering: 1, 1, 1, 1. Appetite: 2, 2, 1, 1. Medication: 2, 2, 2, 2. PROMIS Depression sum scores have been 23, 19, 26, 19. PROMIS Anxiety sum scores have been 17, 18, 17, 18.

Explanation of scores: WHO5: 5 questions each max score of 5, add the totals for each question (max 25) and then multiply the sum by 4 to get a percentage out of 100. Higher score indicates better wellbeing. Mental Health Functional Impairment (MHFI): 6 questions, each max score of 2. Higher scores indicate symptom improvement. Depression: 7 questions each max score of 5, add the totals for each question (max 35). Lower score indicates lower depression levels. Anxiety: 5 questions each max score of 5, add the totals for each question (max 25). Lower score indicates lower anxiety levels. N/A (Not Applicable) indicates that the client selected the N/A answer choice. N/R (Not Reported) indicates that the client did not select any answer choice.

Interpretation and Implications by PT: Clients MBC measures indicate an improvement in the clients mental health. Client reports that this is due to feeling more energized this week and productive. Therapist and client will continue to explore how these things impact the clients mental health so that his MBC measures can continue to improve.

TREATMENT PLAN OBJECTIVES

• Major depressive disorder, recurrent severe without psychotic features
 • Decrease Frequent or recurrent thoughts of death, suicidal thoughts, suicide attempts or suicide from 4 per week to 1 per week in the next 8 week(s) as measured by Clinician observation
• Anxiety disorder, unspecified
 • Decrease Sense of impending doom or danger from 7 per week to 4 per week in the next 8 week(s) as measured by Clinician observation

INTERVENTIONS:

• Anxiety disorder, unspecified
• DBT: Develop and establish healthy, flexible boundaries to promote improve interpersonal effectiveness in relationships.
• Psychoeducation: Combine the elements of cognitive behavior therapy, group therapy, and education to provide the client and family knowledge about symptoms, diagnosis, and treatment to improve collaboration with mental health professionals for a better overall outcome.

SUMMARY: The session focused on identifying and understanding the core belief of "not being good enough" that drives many of the client's self-defeating behaviors and depressive symptoms. The therapist proposed implementing inner child work to address the wounded seven-year-old who internalized critical messages about worthiness and deserving good things. This therapeutic approach targets the root cause of the client's self-punishment patterns and aims to create new neural pathways that support self-compassion and healthy self-advocacy.

MEDICATIONS

Client reported taking medications as prescribed.
PLAN

Connect with and explore feelings of the seven-year-old version of themselves, particularly focusing on how it felt when their father was critical about grades
Continue attending group therapy sessions three times per week (Monday, Tuesday, Wednesday)
Next individual therapy session scheduled for Friday at 2:00 PM

SUBSTANCE USE

None

EATING-DISORDER BEHAVIORS

None reported

CLIENT SESSION SUMMARY

No session summary available - refer to clinical session notes

Signed electronically by Emma Stein, LMSW, Associate Primary Therapist on 01/23/2026 1:22 pm in ElationHealth

Co-signed electronically by Stephanie VanAlstyne, LCSW, Clinical Supervisor on 02/01/2026 2:29 pm

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Individual Note

ElationHealth

Patient Name: Joseph Mahoney

D.O.B.: 05/01/1969; 56 yrs, 8 mo at the time of visit
Seen by Emma Stein, LMSW, Associate Primary Therapist

Date of Encounter: 01/16/2026

Exam Reason (CC): Individual Therapy

ATTENDANCE

Session type: Individual
Duration: 60mins (12:00 PM - 1:00 PM MT)

Client was present and seen via Zoom. Client confirmed to be in a confidential setting. Client confirmed identity.

SESSION OVERVIEW

PRESENTING SYMPTOM: The client is presenting with depressive symptoms characterized by lack of motivation and what they describe as an "invisible force" preventing them from taking action on job applications and self-care activities. They report feeling mentally frustrated, impatient, and stuck despite actively working on projects and overhauling their website and portfolio. The client experiences a dysregulated nervous system with hypervigilance and describes feeling like they are "spinning their wheels" waiting for something to "pay off" from their efforts. These symptoms are significantly impacting their ability to function in job searching and daily motivation, with the client rating themselves in the "1 to 3 range" on a 1-10 scale during group therapy sessions.

DESCRIPTION OF SESSION: The session focused extensively on exploring the client's core schema of "not being good enough" through coherence therapy concepts and inner child work. The therapist guided the client through examining childhood memories, particularly traumatic experiences with their father during report card reviews that reinforced feelings of inadequacy and fear. The client described dissociative responses and hypervigilance during these childhood confrontations. A significant portion of the session involved contrasting this wounded inner child with the client's confident, capable self that emerged through soccer, where they felt self-assured and "good enough." The therapist used parts work to help the client access both the scared 7-year-old part and the confident soccer player/coach part, creating cognitive dissonance around their core belief. The session incorporated mindfulness and visualization techniques as the client described a powerful experience of comforting their inner child. The therapeutic approach aimed to restructure negative thought patterns by highlighting evidence that contradicts the "not good enough" schema through the client's soccer achievements and coaching success.

CLIENT ASSESSMENT

Mental Status Exam was completed
- Observations
  - Appearance: Neat
  - Speech: Normal
  - Eye contact: Normal
  - Motor activity: Normal
  - Affect: Full
  - Comments: None
- Mood
  - Anxious; Depressed
  - Comments: None

• Cognition
 • Orientation Impairment: None
 • Memory Impairment: None
 • Attention: Normal
 • Comments: None
• Perception
 • Hallucinations: None
 • Other: None
 • Comments: None
• Thoughts
 • Suicidality: None
 • Homicidality: None
 • Delusions: None
 • Comments: None
• Behavior
 • Cooperative
 • Comments: None
• Insight
 • Good
 • Comments: None
• Judgement
 • Good
 • Comments: None

MBC survey was last completed on 01/16/26 at 12:53 PM MT

PT reviewed client reported outcomes progress with client.

The client completed their first MBC Survey on 01/02/26. Their most recent MBC survey was completed on 01/16/26. WHO-5 overall scores have been 20, 44, 28. Mental Health Functional Impairment (MHFI) scores have been School/Work: 2, N/A, N/A. Sleep: 1, 1, 2. Brushing Teeth: 1, 1, 1. Showering: 1, 1, 1. Appetite: 2, 2, 1. Medication: 2, 2, 2. PROMIS Depression sum scores have been 23, 19, 26. PROMIS Anxiety sum scores have been 17, 18, 17.

Explanation of scores: WHO5: 5 questions each max score of 5, add the totals for each question (max 25) and then multiply the sum by 4 to get a percentage out of 100. Higher score indicates better wellbeing. Mental Health Functional Impairment (MHFI): 6 questions, each max score of 2. Higher scores indicate symptom improvement. Depression: 7 questions each max score of 5, add the totals for each question (max 35). Lower score indicates lower depression levels. Anxiety: 5 questions each max score of 5, add the totals for each question (max 25). Lower score indicates lower anxiety levels. N/A (Not Applicable) indicates that the client selected the N/A answer choice. N/R (Not Reported) indicates that the client did not select any answer choice.

Interpretation and Implications by PT: Clients MBC measures indicate that the clients symptoms of mental health need improving. Client shared that he woke up the past couple of days not feeling 100%, client shared that he couldn't fully identify what was making him not feel great. Therapist and client will continue to explore core beliefs and when the client gets triggered to "not feeling good enough" in order to improve his measures.

TREATMENT PLAN OBJECTIVES

• Anxiety disorder, unspecified
 • Decrease Sense of impending doom or danger from 7 per week to 4 per week in the next 8 week(s) as measured by Clinician observation
• Major depressive disorder, recurrent severe without psychotic features
 • Decrease Frequent or recurrent thoughts of death, suicidal thoughts, suicide attempts or suicide from 4 per week to 1 per week in the next 8 week(s) as measured by Clinician observation

INTERVENTIONS:
• Anxiety disorder, unspecified
 • Psychoeducation: Combine the elements of cognitive behavior therapy, group therapy, and education to

provide the client and family knowledge about symptoms, diagnosis, and treatment to improve collaboration with mental health professionals for a better overall outcome.
• DBT: Develop and establish healthy, flexible boundaries to promote improve interpersonal effectiveness in relationships.

SUMMARY: The session utilized coherence therapy principles and inner child work to address the client's core schema of inadequacy by creating cognitive dissonance between their "not good enough" belief and evidence of competence through soccer experiences. The therapeutic intervention of accessing both the wounded 7-year-old part and the confident adult part helped the client recognize the coexistence of these different aspects of themselves. Progress was evident in the client's ability to viscerally access feelings of confidence and self-worth when discussing their soccer experiences, demonstrating that alternative neural pathways to the "not good enough" response do exist and can be strengthened.

MEDICATIONS

Client reported taking medications as prescribed.
PLAN

Client will reflect on the work done during the session regarding the contrast between their 7-year-old wounded part and their confident adult soccer player/coach part
Client will practice accessing the confident feelings associated with their soccer experiences when feeling stuck or inadequate
Next session will explore the part of the client that "wants them to suffer" and convinces them they deserve to struggle
Client confirmed they will attend the next session at the regular time

SUBSTANCE USE

None

EATING-DISORDER BEHAVIORS

None reported

CLIENT SESSION SUMMARY

No session summary available - refer to clinical session notes

Signed electronically by Emma Stein, LMSW, Associate Primary Therapist on 01/16/2026 1:48 pm in ElationHealth

Co-signed electronically by Stephanie VanAlstyne, LCSW, Clinical Supervisor on 01/23/2026 2:52 pm

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Individual Note

ElationHealth

Patient Name: Joseph Mahoney

D.O.B.: 05/01/1969; 56 yrs, 8 mo at the time of visit
Seen by Emma Stein, LMSW, Associate Primary Therapist

Date of Encounter: 01/09/2026

Exam Reason (CC): Individual Therapy

ATTENDANCE

Session type: Individual
Duration: 60mins (12:00 PM - 1:00 PM MT)

Client was present and seen via Zoom. Client confirmed to be in a confidential setting. Client confirmed identity.

SESSION OVERVIEW

PRESENTING SYMPTOM: The client is presenting with depression-related symptoms, including periods of low energy and fatigue, particularly following intensive group therapy sessions with new participants. They explicitly mentioned experiencing anhedonia in the past, describing it as an "awful feeling" characterized by numbness and a "why bother, nothing matters" attitude. The client reports being emotionally drained from holding space for others in group therapy and experiencing what they describe as "psychic stench" - a negative energy they emanate during difficult periods. These symptoms appear to be related to major life stressors including divorce, job loss, and a period of homelessness, though they report being "straightened out pharmaceutically" for over a year. The fatigue and emotional exhaustion are currently impacting their ability to maintain consistent energy levels, though they continue to engage actively in treatment and self-care practices.

DESCRIPTION OF SESSION: The session began with the client discussing their current low energy levels following intensive group therapy sessions with new participants, explaining how their empathetic nature and tendency to deeply focus on others' stories creates emotional exhaustion. The therapist and client explored the client's pattern of holding space for others and how this connects to their own experiences with depression and anhedonia. A significant portion of the session focused on examining the client's core beliefs about not being "good enough" and deserving to suffer, tracing these beliefs back to their teenage years and exploring how these negative thought patterns contributed to their refusal to seek help during their crisis period. The client demonstrated significant insight into their "shadow self" - describing it as a tough, assertive part of themselves that they had historically repressed. They discussed the process of integrating this shadow aspect, moving from a pattern where different parts of their personality would take control to a more blended, integrated approach. The therapist introduced the concept of coherence therapy as it related to the client's described process of bringing subconscious beliefs to conscious awareness and working to integrate different aspects of their personality. The client showed strong self-awareness regarding their tendency toward self-flagellation and how their masking behaviors developed as coping mechanisms.

CLIENT ASSESSMENT

Mental Status Exam was completed
- Observations
- Appearance: Neat
- Speech: Normal
- Eye contact: Normal
- Motor activity: Normal

• Affect: Full
• Comments: None
• Mood
• Anxious
• Comments: None
• Cognition
• Orientation Impairment: None
• Memory Impairment: None
• Attention: Normal
• Comments: None
• Perception
• Hallucinations: None
• Other: None
• Comments: None
• Thoughts
• Suicidality: None
• Homicidality: None
• Delusions: None
• Comments: None
• Behavior
• Cooperative
• Comments: None
• Insight
• Good
• Comments: None
• Judgement
• Good
• Comments: None

The client completed their first MBC Survey on 01/02/26. Their most recent MBC survey was completed on 01/09/26. WHO-5 overall scores have been 20, 44. Mental Health Functional Impairment (MHFI) scores have been School/Work: 2, N/A. Sleep: 1, 1. Brushing Teeth: 1, 1. Showering: 1, 1. Appetite: 2, 2. Medication: 2, 2. PROMIS Depression sum scores have been 23, 19. PROMIS Anxiety sum scores have been 17, 18.

Explanation of scores: WHO5: 5 questions each max score of 5, add the totals for each question (max 25) and then multiply the sum by 4 to get a percentage out of 100. Higher score indicates better wellbeing. Mental Health Functional Impairment (MHFI): 6 questions, each max score of 2. Higher scores indicate symptom improvement. Depression: 7 questions each max score of 5, add the totals for each question (max 35). Lower score indicates lower depression levels. Anxiety: 5 questions each max score of 5, add the totals for each question (max 25). Lower score indicates lower anxiety levels. N/A (Not Applicable) indicates that the client selected the N/A answer choice. N/R (Not Reported) indicates that the client did not select any answer choice.

Interpretation and Implications by PT: Clients overall MBC measures indicate some improvement. Client reports that this is due to engaging in vIOP interventions. Client will continue to attend sessions in order to continue to improve their MBC measures.

TREATMENT PLAN OBJECTIVES

• Anxiety disorder, unspecified
• Decrease Sense of impending doom or danger from 7 per week to 4 per week in the next 8 week(s) as measured by Clinician observation
• Major depressive disorder, recurrent severe without psychotic features
• Decrease Frequent or recurrent thoughts of death, suicidal thoughts, suicide attempts or suicide from 4 per week to 1 per week in the next 8 week(s) as measured by Clinician observation

INTERVENTIONS:
• Anxiety disorder, unspecified
• Psychoeducation: Combine the elements of cognitive behavior therapy, group therapy, and education to provide the client and family knowledge about symptoms, diagnosis, and treatment to improve

collaboration with mental health professionals for a better overall outcome.
• DBT: Practice coping ahead to rehearse plans ahead of time and practice coping skills to increase emotional regulation.

SUMMARY: The client is making significant progress in integrating different aspects of their personality, particularly their "shadow self," moving from a pattern of repression to conscious integration and self-acceptance. Their work appears to align with principles similar to Internal Family Systems therapy and coherence therapy, focusing on bringing subconscious beliefs about self-worth to conscious awareness and developing healthier self-concepts. The client's consistent engagement in mindfulness practices and their ability to maintain self-care routines demonstrate positive progress in emotional regulation and distress tolerance skills.

MEDICATIONS

Client reported taking medications as prescribed.
PLAN

Therapist will provide information and resources about coherence therapy for the client to explore
Client will continue attending group therapy sessions 3x per week
Client confirmed they will attend the next individual therapy session at the regular time
Client will continue daily meditation practice and self-care routines including exercise

SUBSTANCE USE

None

EATING-DISORDER BEHAVIORS

None reported

CLIENT SESSION SUMMARY

No session summary available - refer to clinical session notes

Signed electronically by Emma Stein, LMSW, Associate Primary Therapist on 01/09/2026 1:29 pm in ElationHealth

Co-signed electronically by Stephanie VanAlstyne, LCSW, Clinical Supervisor on 01/20/2026 2:06 pm

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Individual Note

ElationHealth

Patient Name: Joseph Mahoney

D.O.B.: 05/01/1969; 56 yrs, 8 mo at the time of visit
Seen by Emma Stein, LMSW, Associate Primary Therapist

Date of Encounter: 01/02/2026

Exam Reason (CC): Individual Therapy

ATTENDANCE

Session type: Individual
Duration: 60mins (12:00 PM - 1:00 PM MT)

Client was present and seen via Zoom. Client confirmed to be in a confidential setting. Client confirmed identity.

SESSION OVERVIEW

PRESENTING SYMPTOM: The client presents with treatment-resistant Major Depressive Disorder, characterized by recurrent major depressive episodes spanning decades. They report a history of two suicide attempts (at age 16 and in their 40s) and describe experiencing the darkest period of their life over the past 2-3 years, including a complete loss of hope. Recently, the client has experienced intense anger and rage that they describe as unprecedented in their life, stating they felt capable of violence with pleasure, which frightened them. These symptoms have significantly impacted their functioning, leading to homelessness (living in their car for 16 months), unemployment for 2.5+ years despite extensive job searching, and social isolation with difficulty maintaining close relationships.

DESCRIPTION OF SESSION: During this initial session, the client provided extensive background information about their mental health history and current circumstances. The client discussed their childhood trauma, including an abusive father who created an environment of hypervigilance and fear, leading to the development of sophisticated masking behaviors as a survival mechanism. They explored how this childhood experience created a core belief of 'not being good enough' that continues to impact their life decisions and relationships. The client shared their recent experiences of homelessness, divorce after 30 years of marriage, and prolonged unemployment in their field of software design. They discussed their previous therapeutic work, including Cognitive Behavioral Therapy (CBT), Internal Family Systems (IFS), and shadow work, demonstrating significant self-awareness about their patterns and triggers. The client also reported recent ketamine therapy in Colorado that provided some relief before experiencing a gap in care when relocating to New York. The session focused on building rapport and understanding the client's current presentation, including their recent experience of intense anger and rage that felt foreign to them.

CLIENT ASSESSMENT

Mental Status Exam was completed
- Observations
  - Appearance: Neat
  - Speech: Normal
  - Eye contact: Normal
  - Motor activity: Normal
  - Affect: Full
  - Comments: None
- Mood
  - Anxious; Depressed
  - Comments: None

• Cognition
 • Orientation Impairment: None
 • Memory Impairment: None
 • Attention: Normal
 • Comments: None
• Perception
 • Hallucinations: None
 • Other: None
 • Comments: None
• Thoughts
 • Suicidality: Ideation
 • Homicidality: None
 • Delusions: None
 • Comments: None
• Behavior
 • Cooperative
 • Comments: None
• Insight
 • Good
 • Comments: None
• Judgement
 • Good
 • Comments: None

The client completed their first MBC Survey on 01/02/26. Their most recent MBC survey was completed on 01/02/26. WHO-5 overall scores have been 20. Mental Health Functional Impairment (MHFI) scores have been School/Work: 2. Sleep: 1. Brushing Teeth: 1. Showering: 1. Appetite: 2. Medication: 2. PROMIS Depression sum scores have been 23. PROMIS Anxiety sum scores have been 17.

Explanation of scores: WHO5: 5 questions each max score of 5, add the totals for each question (max 25) and then multiply the sum by 4 to get a percentage out of 100. Higher score indicates better wellbeing. Mental Health Functional Impairment (MHFI): 6 questions, each max score of 2. Higher scores indicate symptom improvement. Depression: 7 questions each max score of 5, add the totals for each question (max 35). Lower score indicates lower depression levels. Anxiety: 5 questions each max score of 5, add the totals for each question (max 25). Lower score indicates lower anxiety levels. N/A (Not Applicable) indicates that the client selected the N/A answer choice. N/R (Not Reported) indicates that the client did not select any answer choice.

Interpretation and Implications by PT: Client took the MBC survey for the first time today. Clients results indicate that he experiences severe symptoms of anxiety and depression. Therapist and client will continue to explore core beliefs that drive the clients behavior in order to improve MBC measures.

TREATMENT PLAN OBJECTIVES

No objectives. Treatment planning in progress with primary therapist.

MEDICATIONS

Client reported taking medications as prescribed.
PLAN

Therapist will send treatment plan through on Monday
Client will attend next session on Friday
Continue exploring subconscious beliefs and behavioral patterns that stem from childhood experiences
Focus on understanding the connection between core beliefs of 'not being good enough' and current life challenges

SUBSTANCE USE

None

EATING-DISORDER BEHAVIORS

None reported

CLIENT SESSION SUMMARY

No session summary available - refer to clinical session notes

Signed electronically by Emma Stein, LMSW, Associate Primary Therapist on 01/02/2026 1:59 pm in ElationHealth

Co-signed electronically by Ashley Johnson, LCSW, Clinical Supervisor on 01/07/2026 5:23 pm

charlie health

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Individual Note

ElationHealth

Patient Name: Joseph Mahoney

D.O.B.: 05/01/1969; 56 yrs, 7 mo at the time of visit
Seen by Emma Stein, LMSW, Associate Primary Therapist

Date of Encounter: 12/26/2025

Exam Reason (CC): Individual Therapy

Client did not attend session

REASON: No - Canceled

Reason for the cancelation:
Clinician is on vacation

Additional details and/or attempts to contact client:
Therapist will be on vacation.

Signed electronically by Emma Stein, LMSW, Associate Primary Therapist on 12/11/2025 9:06 am in ElationHealth