



# SessionGlance

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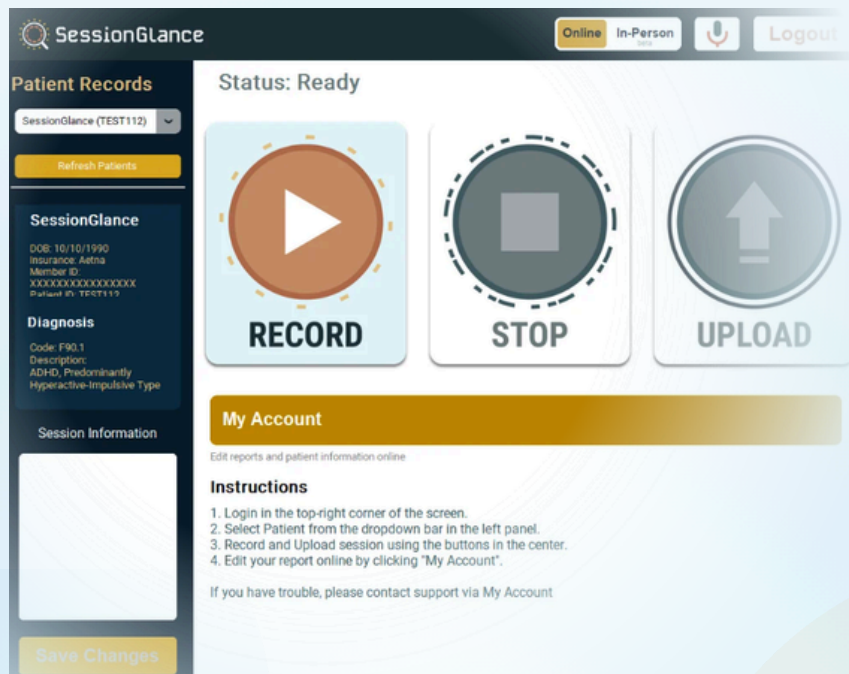
BEHAVIORAL  
HEALTH TECH

**Nashville, TN**  
**September 22-24**



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## One behavioral health visit. Three different kinds of value.

Every visit contains an assessment, interpretation, formulation, feedback, care planning, and documentation that can be easy to lose.

### Clients

Clear summaries for reflection, recall, and follow-through between sessions.

### Clinicians

Editable drafts organize symptoms, functioning, intervention, interpretation, planning, and recommendations.

### Practices

A repeatable workflow supports assessment-based reimbursement when the work is medically necessary and payer-supported.



# Therapy includes more than the face-to-face conversation.

Clinicians assess symptoms and functioning, track risk, integrate history, revise formulation, make treatment decisions, and translate complex moments into something clients can use.

### Assessment work

Symptoms, functioning, risk, progress, barriers, resilience, and treatment response.

### Clinical thinking

Interpretation, formulation, decision-making, and treatment planning.

### Client feedback

A client-facing summary for recall, engagement, reflection, and continuity.

### Practice sustainability

A repeatable way to document assessment-level work that supports reimbursement when medically necessary and payer-supported.

## WORKFLOW

# Assess. Interpret. Plan. Summarize. Document. Review.

SessionGlance is designed to keep the clinical process connected.

01

### Behavioral Health Visit

Clinician conducts Psychotherapy/Psychiatry appointment as usual.

02

### Record + Upload

Audio is recorded locally and uploaded securely.

03

### Draft Outputs

SessionGlance organizes client-facing and clinician-facing materials.

04

### Clinician Review

Clinician reviews and edits draft clinical material to best reflect client's progress and clinical work.

05

### Secure Feedback

The finalized After Visit Summary can be sent through the protected client-link workflow.



DESIGNED AROUND PROTECTING INFORMATION FROM RECORDING TO REPORT

# The security model starts from a simple assumption: everything the platform touches must be protected

## 2FA

Required for login

## BAA

Business Associate Agreements with all organizations

## 0

OpenAI data retention under BAA

## 1

Access point to client data

## Encrypted storage + transfer

Audio, transcripts, and reports are encrypted atrest and in transit; audio uploads over HTTPS.

## Speech-to-text in the environment

Open-source Whisper runs on SessionGlance servers; audio is not sent to a third-party transcription service.

## OpenAI for drafting

OpenAI API's used under a BAA with zero data retention; OpenAI does not receive audio and does not keep/train on the transcript.

## Scoped access + logging

Access is clinician/practices coped; report activity is logged.



FOUR DOCUMENTS FROM ONE VISIT

## SessionGlance is built to capture the work clinicians do and transform it into billable documentation

01

### After Visit Summary

Client-facing feedback that supports recall, reflection, engagement, and continuity of care.

02

### Psychotherapy Note

AMA-compliant session notes to reduce the time spent with documentation

03

### Psychological Assessment

Structured assessment report connecting measures, functioning, formulation, and recommendations.

04

### Assessment Note

Documentation of rationale and professional work that support the billing of the CPT code 96130



### After Visit Summary

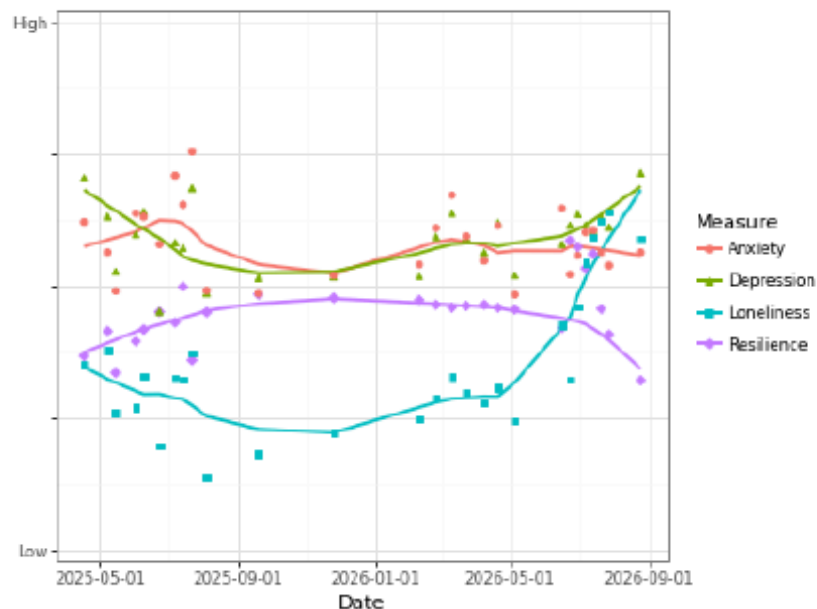
#### Your Session at a Glance

PREPARED FOR SAMPLE SAMPLE · SESSION ON **AUGUST 25, 2026**

*"I do not sit well with being the problem."*

YOUR WORDS, THIS SESSION

#### PROGRESS OVER TIME



Over your last few sessions your anxiety and loneliness scores have stayed about the same, and your resilience scores and one other area have shown some added difficulty. Since you began in April 2025, some areas have steadily improved while others have moved up and down, and that mix is a normal part of the process.

#### WHAT CAME UP

- Relapse to drinking, the shame and self-condemnation after drinking alone, and alcohol used to avoid overwhelming sadness and transitions.
- Forced move from your apartment, the sudden loss of safety and mourning for Detroit, friendships, routines, and the practical chaos of packing.
- Work and financial strain, long physically demanding shifts, underpaid tip structures, and the tension between stable income from bars and pursuing creative production work.



### After Visit Summary

- Diffused sense of self rooted in childhood apology, persistent shame about being the problem, and uncertainty about moving to Philly for Nora versus personal goals.

#### HOW YOUR THERAPIST HELPED

Your therapist reflected back that you had been drinking alone, grieving the move, and swinging between agitation and numbness, and they invited you to describe the first moment you learned you had to leave. Your therapist probed your immediate anger and shutdown, helping you name passivity and overwhelm as familiar responses. They connected those reactions to deeper shame by bringing up the childhood note you read and asking how apologizing had shaped you. Your therapist challenged your catastrophic self-judgments and pointed out thinking patterns that turned single slips into character flaws. They used a machine metaphor to show how rigid plans can collapse when life changes, and they explored your ambivalence about moving by weighing your values for creativity and community. Your therapist encouraged concrete tracking of events, named avoidance as a driver of drinking, and negotiated more frequent, in-person sessions to increase support during the transition.

#### QUESTIONS FOR YOUR WEEK AHEAD

A few questions to carry with you this week. There are no right answers; they are starting points for our next conversation:

1. What emotions come up for you when you think about leaving your current apartment and moving to a new place?
2. How do you feel about the way alcohol plays a role in your life right now? What would your life look like if that role changed?
3. What expectations do you place on yourself that feel difficult to live up to? Are these expectations coming from within you or from others around you?
4. Reflect on a moment recently where you felt proud of yourself. What was different about that moment compared to times when you feel shame?
5. How do you envision your ideal life in terms of relationships, career, and personal happiness? What steps could you take, big or small, towards that vision?

I am looking forward to working with you at our next scheduled session.

Carter Comrie, PHD, LP

License: 6301018158



## Psychotherapy Note

**Session Date:** 2026-08-25

**Internal ID:** CC0019

**Patient:** SAMPLE SAMPLE

**Diagnosis:** Post-Traumatic Stress Disorder, Chronic (F43.12)

**CPT Code:** 90837 (Psychotherapy, 60 minutes)

**Place of Service:** 10 (Telehealth – in patient's home)

**Data:** Provider met with patient for a psychotherapy session on 2026-08-25. The recorded session length was 57 minutes. Present: Client only. Patient attended session on time and was cooperative and engaged. Oriented to person, place, and time. The following were within normal limits: mood, affect, speech, attention, concentration, attitude, insight, judgment/impulse control, memory, thought process, thought content, and perception. Patient denied risk of harm to self or others.

The psychotherapist began with brief rapport work and technical troubleshooting, then used open questions and motivational interviewing to elicit the patient's current concerns about drinking, the upcoming move, and ambivalence about relocating, and they validated the patient's distress. The psychotherapist offered a cognitive formulation (CBT-style) by naming catastrophizing and shame around single drinking events and gently challenged those narratives (cognitive restructuring), using reflective listening and normalization to reframe relapse as a response to stress rather than a character flaw. They introduced a relational/psychodynamic formulation (self-psychology, exploration of childhood apologizing and grief) and used psychoeducation via metaphor (the rigid machine analogy) to illustrate inflexible coping. The psychotherapist also engaged in practical treatment planning, negotiating increased frequency and in-person appointments. The patient disclosed increased drinking, situational examples (casino, drinking alone while



## Psychotherapy Note

packing), expressed guilt and shame, hesitated and said "um" frequently, checked photos when asked about dates, reacted emotionally to a childhood note, at times froze, and ultimately requested twice-weekly in-person work and agreed to the scheduling plan.

The following interventions were utilized in order to make progress on identified treatment goals:

Cognitive refocusing, Cognitive reframing, Exploration of Relationship Patterns, Exploration of coping patterns, Exploration of emotions, Interactive feedback, Psychoeducation, Reflective listening, Structured problem solving

**Assessment:** Progress toward treatment goals, as rated by the clinician: distress tolerance deteriorated; sense of self deteriorated; behavioral repertoire maintained; overall adaptivity deteriorated.

**Complicating Concerns Impacting Client's Condition:** Client is unable to share with others due to nature of problem(s); History of severe trauma impacting current functioning; Client presenting with acute issues; Client in crisis.

**Plan:** Continue weekly.

**Signed:**

Carter Comrie, PHD, LP  
License: 6301018158



### Psychological Assessment

**Internal ID:** CC0008

**Patient Name:** Fake Fake

**Date of Report:** 2026-08-07

**Evaluator:** Carter Comrie PHD LP

**Supervisor:** Carter Comrie PHD LP

**Type of Evaluation:** Weekly Reevaluation

**Previous Evaluation Date:** 2025-07-01

**Initial Diagnosis:** F41.1 (Generalized Anxiety Disorder)

#### Assessment Rationale

The patient sought psychological testing due to a variety of psychological concerns, with a primary focus on evaluating the effectiveness of their current psychotherapy in addressing the challenges associated with their diagnosis of Generalized Anxiety Disorder (F41.1) and determining additional treatment recommendations. Given the severity of the patient's symptoms and the resulting functional impairments, it was recommended that Fake Fake undergo further psychological evaluation to assess the progress of their treatment, monitor symptom severity, identify potential barriers to progress, and determine whether any modifications to the current treatment plan are warranted. Fake Fake agreed to this recommendation and actively participated in the assessment process.

This evaluation is designed to assess the patient's current psychological functioning and progress toward treatment goals. The primary purpose is to enhance treatment effectiveness by identifying any therapeutic approaches that may not be adequately addressing the patient's needs and by recommending alternative or supplemental strategies tailored to their clinical presentation. Psychological testing is used to measure the patient's functional capacity, evaluate cognitive, emotional, and behavioral factors contributing to their difficulties, and provide objective data regarding symptom severity to evaluate the effectiveness of current interventions. In addition, the assessment aims to identify psychological strengths and potential barriers to progress, which will inform ongoing treatment planning and support more targeted, individualized interventions.

#### Introduction

This evaluation examines Fake's presenting psychological concerns and evaluates the effectiveness of psychotherapy in addressing these concerns. The patient is currently receiving treatment for Generalized Anxiety Disorder (F41.1), with symptoms that have resulted in significant functional impairments across multiple domains of daily life. The evaluation aims to provide a comprehensive understanding of the patient's psychological functioning, symptomatology, and response to treatment, ensuring that therapeutic interventions remain tailored to their evolving clinical needs.

#### Presenting Concerns

**Primary Diagnosis:** F41.1 (Generalized Anxiety Disorder)



The patient presentation is consistent with Generalized Anxiety Disorder (F41.1). This diagnosis applies when the individual experiences excessive anxiety and worry, occurring more days than not for at least six months, about a number of events or activities such as work, health, finances, or interpersonal relationships. The worry is difficult to control and is accompanied by physiological and cognitive symptoms that cause clinically significant distress or impairment in social, occupational, or other areas of functioning. The disturbance is not attributable to substance use, a medical condition, or another psychiatric disorder.

**Core Symptoms Include:**

- Excessive worry or apprehensive expectation about multiple domains of life
- Difficulty controlling or reducing worry
- Restlessness, feeling keyed up, or on edge
- Fatigue or easily becoming tired
- Difficulty concentrating or mind going blank
- Muscle tension, tightness, or soreness
- Sleep disturbance, including difficulty falling or staying asleep
- Irritability or heightened emotional sensitivity

**Associated Cognitive and Behavioral Features:**

- Persistent anticipation of worst-case scenarios
- Overestimation of potential danger or failure
- Chronic indecisiveness and reassurance-seeking
- Avoidance of situations that may provoke worry
- Heightened startle response and somatic hyperarousal
- Impaired relaxation or persistent sense of internal agitation

**Diagnostic Considerations:**

- Anxiety and worry occur more days than not for at least six months.
- Symptoms are pervasive, not limited to specific situations or stimuli.
- The anxiety is not confined to features of another disorder (e.g., panic, social anxiety, OCD).
- The symptoms cause clinically significant distress or functional impairment.

**Functional Impairment Summary:**

Generalized Anxiety Disorder leads to chronic emotional and physiological hyperarousal, interfering with concentration, decision-making, and task performance. The individual experiences persistent worry, fatigue, and irritability, often leading to reduced productivity and strained interpersonal relationships. Constant tension and vigilance contribute to functional inefficiency and decreased quality of life, as the person remains in a heightened state of apprehension and internal restlessness.

**Assessment Battery and Rationale**

To support diagnostic clarification, monitor treatment progress, and guide therapeutic planning, the following measures were scored by SessionGlance from the clinical session record and reviewed by the clinician. These measures were selected to evaluate symptom severity, psychological functioning, and overall psychosocial adaptation in the context of Generalized Anxiety Disorder (F41.1).



### **AAQ-II – Acceptance and Action Questionnaire**

The AAQ-II evaluates psychological inflexibility and experiential avoidance. Respondents rate items assessing their willingness to experience unwanted thoughts and emotions while engaging in valued behaviors. This instrument helps identify processes relevant to emotional regulation and behavioral engagement. To determine severity, the average of the responses is calculated with score ranging from 0 - 7, with higher scores reflecting greater levels of avoidance of internal experiences and less flexibility in responding to distress.

This measure helps identify Fake's psychological inflexibility and experiential avoidance and supports the evaluation of the effectiveness of their current psychotherapy treatment in addressing and assessing the patient's willingness for change.

### **GAD-7 – Generalized Anxiety Disorder Scale**

The GAD-7 assesses the frequency of core anxiety symptoms, including excessive worry and difficulty controlling anxious thoughts. The GAD-7 is a 7-item scale that has reporting scores from 0 to 3 on all the questions. It investigates how often the patient has been bothered by seven different symptoms of anxiety during the last two weeks with response options such as: "not at all," "several days," "more than half the days," and "nearly daily" scored as 0, 1, 2, and 3, respectively. To determine severity, the average of the responses is calculated with score ranging from 0 - 3, with "3" being the most severe.

This measure helps identify Fake's anxiety-driven distress and supports the evaluation of the effectiveness of their current psychotherapy treatment in addressing the challenges related to their diagnosis of Generalized Anxiety Disorder (F41.1) and determining additional treatment recommendations. The GAD-7 aims to measure the patient's anxious distress and provide objective measurements of symptom severity to evaluate treatment effectiveness.

### **UCLA Loneliness Scale (UCLA-LS)**

The UCLA-LS assesses subjective perceptions of loneliness and dissatisfaction with social connectedness. It examines how individuals perceive their relational closeness and social support networks. Higher scores indicate greater perceived loneliness or social isolation, constructs that are associated with various mental health risks. This measure offers insight into the patient's interpersonal experience and contributes to understanding social-emotional context.

### **PHQ-9 – Patient Health Questionnaire**

The Patient Health Questionnaire-9 (PHQ-9) is a 9-item self-administered screening tool used to score, diagnose severity, and monitor treatment response for depression. It evaluates symptoms over the past 2 weeks on a 0 to 3 point scale. It investigates how often the patient has been bothered by nine different symptoms of depression during the last two weeks with response options such as: "not at all," "several days," "more than half the days," and "nearly daily" scored as 0, 1, 2, and 3, respectively. To determine severity, the average of the responses is calculated with score ranging from 0 - 3, with "3" being the most severe.

This measure helps identify Fake's depression-driven distress and supports the evaluation of the effectiveness of their current psychotherapy treatment in addressing the challenges related to their diagnosis of Generalized Anxiety Disorder (F41.1) and determining additional treatment recommendations. The PHQ-9 aims to measure the patient's depressive affect and provide objective measurements of symptom severity to evaluate treatment effectiveness.



### Clinician-Rated Functional Domain Assessment

A clinician-rated appraisal of adaptive functioning across five domains: quality of friendships and family relations, romantic/sexual relationships, tolerance for affections, insight, and problem-solving/adaptive capacity. Each domain is rated on a 1–10 scale, with higher scores reflecting stronger functioning.

### Subjective Evaluation of Symptoms and Functioning

Clinical observation and patient self-report indicated **modest improvement** in overall functioning. The patient continues to experience symptoms consistent with Generalized Anxiety Disorder, including low mood, emotional reactivity, and intermittent hyperarousal. However, they are demonstrating increased insight into the psychological and environmental factors contributing to their distress. This developing awareness allows the patient to better recognize patterns between internal emotional states and external stressors, supporting more intentional use of coping strategies in daily life.

Psychotherapy has provided a structured space for both cognitive and emotional processing of past experiences and current psychosocial stressors. This process has facilitated gradual perspective shifts, greater emotional clarity, and a reduction in overall symptom intensity. Interventions focused on emotional regulation, cognitive restructuring, and behavioral activation have helped the patient re-engage with daily routines, self-care practices, and interpersonal roles. While affective variability remains, the patient is increasingly able to implement coping strategies with moderate success, demonstrating growth in their ability to manage emotional challenges more effectively over time.

Psychotherapy has also offered consistent support to reinforce therapeutic skills and stabilize functioning. The patient has responded positively to this structure, expressing readiness to consolidate progress, deepen self-awareness, and develop greater consistency in adaptive behavioral and emotional patterns. As treatment continues, increased emphasis on relapse prevention, clarification of core values, and further development of sustainable coping strategies is expected to strengthen long-term recovery and reduce vulnerability to future symptom escalation. These emerging changes reflect meaningful therapeutic gains and an evolving capacity for resilience.

### Objective Rating of Symptoms and Functioning

The following measure results were derived from the session record and reviewed by the clinician:

**AAQ-II:** 5.2 out of 7. Decreased from the previous session.

**GAD-7:** 2.4 out of 3. Increased from the previous session.

**UCLA-LS:** 2.86 out of 4. Increased from the previous session.

**PHQ-9:** 1.67 out of 3. Carried forward from the prior session; this session's record did not provide enough evidence to score it.

### Functional Domain Assessment

Quality of Friendships/Family Relations: 6, Fair Functioning

Romantic/Sexual Relationships: 6, Fair Functioning

Tolerance for Affections: 7, Moderate Functioning



Insight: 7, Moderate Functioning

Problem-Solving and Adaptive Capacity: 7, Moderate Functioning

### Clinical Formulation

#### Distress Tolerance

The clinician has been consistently monitoring how the patient responds to distressing affect in their daily life. Observations indicate **modest improvement** in the patient's overall ability to manage psychological distress. Recent psychosocial stressors have provided important opportunities to observe how the patient approaches moments of heightened emotional intensity. The patient relies on a combination of cognitive strategies—including thought challenging, attentional refocusing, and structured problem-solving methods—to regulate distress. While these techniques are increasingly integrated into their day-to-day functioning, their effectiveness varies depending on contextual demands and emotional load. The patient shows a growing capacity to anticipate stress reactions and mobilize skills more deliberately, though the intensity and complexity of certain emotional experiences continue to present challenges. As such, targeted work on distress tolerance remains a central and evolving focus of ongoing treatment.

#### Sense of Self

Clinical observations reflect **modest improvement** in the patient's evolving sense of self. Reflective interventions have facilitated deeper emotional insight and self-understanding by illuminating recurring emotional themes, relational patterns, and underlying belief systems that have historically contributed to internal conflict. Through this process, the patient is gradually developing a more coherent and integrated understanding of their self-concept, emotional triggers, and interpersonal dynamics. Therapeutic exploration has focused on examining unresolved relational issues and emotional conflicts that shape their current identity experience. Over time, the patient has demonstrated a growing willingness to engage with these vulnerable areas, supporting incremental expansion of self-awareness. Continued therapeutic attention in this domain is warranted, as identity consolidation and self-acceptance often provide the structural foundation for durable emotional stability and adaptive functioning.

#### Behavioral Repertoire

The clinician has observed **limited and inconsistent improvement** in the patient's behavioral repertoire. Therapeutic work in this area has emphasized the identification, monitoring, and refinement of coping strategies to ensure alignment with personal values and long-term functional goals. Behavioral activation has played a central role, focusing on increasing participation in meaningful daily activities while addressing avoidance patterns that limit engagement. The patient's capacity to initiate and sustain these behaviors varies depending on emotional context and perceived demands, but there are clear indications of growing awareness regarding the relationship between avoidance and psychological distress. Through this work, the patient is learning to more intentionally structure their routines and behavioral choices in ways that promote psychological flexibility and functional stability.

#### Ongoing Assessment

Serial assessments and clinical observations have been used to monitor psychological functioning across emotional, cognitive, and behavioral domains. The patient demonstrates



### **only modest or inconsistent gains in insight, regulation, and treatment engagement.**

These findings offer a comprehensive view of the patient's clinical trajectory, highlighting areas of growth as well as domains that remain vulnerable to symptom fluctuation. This integrated approach to assessment allows for ongoing refinement of the treatment plan, ensuring that interventions remain responsive to the patient's evolving clinical presentation, therapeutic needs, and overarching goals for psychological functioning and well-being.

The patient demonstrated measurable progress toward his therapy goals during the session, exhibiting greater tolerance for strong emotions, emerging clarity about his personal narrative, and an increased set of concrete behavioral options for managing stress. He cited a specific example of distress tolerance when he deliberately stepped away during an overstimulating family outing and later greeted his daughter calmly, describing that response as a meaningful success. The psychotherapist used focused questioning and reflective summarizing to help him connect his frustrations to core values (service, competence, care), which supported an enriched self-story and reduced the tendency to equate others' errors with personal failure. He is also beginning to reframe work problems as organizational and procedural challenges rather than indictments of his character, and he accepted homework to document accomplishments and parenting growth to further consolidate that narrative shift. The psychotherapist introduced practical behavioral strategies, including revising and scripting communications, planning delegation and negotiation options, and assigning reflective writing, and the patient reported testing softer email language and relying on partner support in moments of overload. These changes have expanded his behavioral repertoire by offering alternative actions to impulsive anger and all-or-nothing responses, while he continues to acknowledge ongoing workload strain that will require continued practice. Overall, the patient is making early but meaningful gains: he tolerates distress more adaptively in family contexts, articulates a more integrated professional identity, and is actively practicing a wider range of organizational and interpersonal behaviors as discussed in session.

### **Conclusion**

Since the previous evaluation, Fake —diagnosed with Generalized Anxiety Disorder (F41.1)—has continued to demonstrate active participation in psychotherapy. This level of engagement has supported meaningful therapeutic gains across multiple domains of psychological functioning.

In the context of Generalized Anxiety Disorder (F41.1), the patient has also demonstrated **maintained progress** in managing anxiety and stress. Fake appears to be committed to developing and consistently applying a range of coping strategies, allowing for improved navigation of both acute stressors and chronic emotional discomfort.

To further support treatment progress and deepen emotional integration, the following enhancements are recommended:

- **Mentalization and Perspective-Taking Exercises:** Incorporate interventions aimed at enhancing the patient's ability to understand and reflect on their own and others' internal states, improving emotional insight and relational functioning.
- **Strengths-Based Interventions:** Integrate structured exploration and application of the patient's existing strengths and competencies to promote resilience, self-efficacy, and a more balanced self-concept.



Additionally, the following targeted strategies may be applied as clinically indicated:

### **Targeted Interventions (As Indicated)**

- **Shame Resilience and Vulnerability Work**

For patients impacted by pervasive shame or fear of judgment, interventions focused on identifying shame triggers, fostering vulnerability tolerance, and promoting authentic self-expression can reduce emotional avoidance and self-criticism.

- **Identity Integration and Role Exploration**

For patients experiencing identity diffusion or navigating major transitions, structured reflection and role exploration can promote coherence and agency.

- **Relational Rupture and Repair Work**

For challenges in maintaining therapeutic or interpersonal connections, intentional exploration and repair of relational ruptures can model healthy communication, build trust, and deepen emotional engagement.

- **Life Transitions and Role Adjustment Planning**

For patients undergoing significant developmental, occupational, or relational shifts, collaborative planning around role transitions can support adaptation, reduce stress, and prevent destabilization.

Continued monitoring of the patient's clinical trajectory will be essential to ensure these recommendations remain responsive to evolving therapeutic goals and needs.

### **Signature**

Carter Comrie, PHD, LP



## Assessment Progress Note

**Assessment Date:** 2026-08-31

**Internal ID:** CC0019

**Patient:**

**CPT Code:** 96130

**Place of Service:** 11 (Office)

**Rationale:** Patient presented with multiple symptoms associated with Post-Traumatic Stress Disorder, Chronic (F43.12) on 2026-08-25. Clinician and [REDACTED] have agreed to ongoing psychological assessment of patient's psychological functioning and progress towards treatment goals to assist with better understanding of [REDACTED] functioning and to assist with treatment planning. [REDACTED] presented with cognitive complaints related to memory, attention, and executive functioning, requiring psychological assessment to monitor cognitive functioning, emotional regulation, functional impairment, and treatment recommendations. Psychological testing was determined to be medically necessary when as the following conditions were met (Select at least one of the following):

1. Measure a psychological disorder and its severity and functional impairment to determine psychiatric diagnosis when a mental illness is suspected.
2. Measure behavioral factors that impact management of the disorder.
3. Measure functional capacity to delineate specific cognitive, emotional, or behavioral bases of functional complaints.
4. Measure psychological barriers and strengths to aid in treatment planning.
5. Perform symptom measurement to objectively measure treatment effectiveness.
6. Measure and confirm or refute clinical impressions obtained from interactions with patients.



## Psychological Assessment Note

**Data:** Professional time documented for this evaluation: pending finalization. This time covered integration of patient data, interpretation of test results and clinical data, clinical decision making, treatment planning, and report writing.

**Assessment Battery:** Psychological assessment involves the use of reliable and research-validated methods (including but not limited to clinical interviewing) and standardized tests to evaluate cognitive, behavioral, and emotional functioning, intellectual abilities, personality, and psychopathology. Domains assessed in a psychological assessment typically consist of mood/emotional conditions and symptoms, cognitive status, adaptive functioning, and behavioral and interpersonal adjustment. The administered assessment battery included the following measures:

**1. Mood/Emotional Conditions and Symptoms:**

1. Patient Health Questionnaire-9. (PHQ-9; Computer Scored-Clinician Reviewed)
2. Generalized Anxiety Disorder-7 (GAD-7; Computer Scored-Clinician Reviewed)

**2. Adaptive Functioning:**

1. Mini Mental Status Exam (MMSE; Clinician Administered)
2. Assessment of Change in Dynamic Functioning (ACDF; Clinician-Reported)

**3. Behavioral and Interpersonal Adjustment**

1. Acceptance and Action Questionnaire - 9 Item Version (AAQ-9; Computer Scored-Clinician Reviewed)
2. Loneliness Scale (LS; Self-Reported)

All measures in the assessment battery have either normed data or cut-offs derived from population metrics, making interpretation from a qualified health provider necessary.

**Results:** The specific results of the psychological evaluation as well as implications for treatment planning are included in the assessment report.



## Psychological Assessment Note

**Feedback:** The feedback report was sent to patient via email on 2026-08-31. Interactive verbal feedback is scheduled during the next psychotherapy session.

**Diagnoses after clinical evaluation:** Post-Traumatic Stress Disorder, Chronic (F43.12)

**Signed:**

Carter Comrie, PHD, LP  
License: 6301018158



### EARLY PILOT FINDINGS

# Early findings suggest stronger engagement and improved functioning

## Engagement

Clients in pilot study had significantly higher treatment adherence

$F(1,47)=18.68$   $p < .001$ ,  $d = 1.26$

## Functioning

Clinician rate their client's functioning

$b = 7.98$   $SE = 3.21$ ,  $p = .02$

## Depression (PHQ)

Trend toward faster depressive improvement

$b = -0.39$ ,  $p = .076$

## Anxiety (GAD)

Trend toward faster anxiety improvement

$b = -0.38$ ,  $p = .078$



RESEARCH POSTER



# Designed with Clinical Work in the Forefront



### **Dr. Carter Comrie**

Clinical health psychologist and co-founder. Background spans private practice, integrated health, hospital-based care, state-level policy, and the VA system.



### **Dr. Alexander "Xander" Krieg**

Licensed clinical psychologist and co-founder. Trained in clinical science and cultural psychology, combining psychotherapy expertise with coding and machine learning. His work focuses on technology that refines human insight rather than replacing it.

