Primary care progress note

Subject: Alex Demo (entirely fictional)

Document / encounter date: May 4, 2026

Author: Dr. Rowan Example, primary care (fictional)

History reported by Alex

Alex Demo reported intermittent worry while helping a family member relocate and sleeping about six hours nightly. Alex described an anxiety episode in 2021 that improved with counseling. No 2021 counseling records were available to this author.

Function and observations

Alex reported continuing a full-time customer-support role, preparing meals independently, and taking regular walks. During this visit, speech was coherent and behavior was cooperative. These observations apply to this visit only.

Plan

The clinician discussed a return appointment if concerns persisted. No work restriction or formal psychological testing was recorded in this note.

SYNTHETIC DATA ONLY - No real patient, clinician, employer, or clinical advice.

Psychological intake note

Subject: Alex Demo (entirely fictional)

Document / encounter date: September 21, 2026

Author: Dr. Mira Example, psychologist (fictional)

Referral and reported event

Alex Demo described a workplace meeting on September 15, 2026. Alex reported that a supervisor raised their voice and that Alex felt threatened. This is Alex's account, recorded on September 21; the clinician did not witness the meeting.

Reported symptoms and observed mental status

Alex reported sleeping four to five hours nightly, replaying the meeting, and losing concentration while answering customer messages. The clinician observed anxious affect, coherent speech, and orientation during this visit. Alex reported no suicidal ideation at this visit; this is a dated report, not a statement about later or current risk.

Function and plan

Alex reported needing extra time to finish household paperwork. The clinician recommended weekly psychotherapy and a temporary reduced work schedule for two weeks, with reassessment. No permanent impairment rating, causation allocation, or credibility determination was made.

SYNTHETIC DATA ONLY - No real patient, clinician, employer, or clinical advice.

Employer meeting memorandum

Subject: Alex Demo (entirely fictional)

Document / encounter date: September 24, 2026

Author: Taylor Example, supervisor at Example Services (fictional)

Source and event date

Taylor Example prepared this memorandum on September 24 about the September 15, 2026 workplace meeting. This is an employer account, not a clinical examination.

Supervisor account

Taylor described a routine discussion of response-time targets and denied raising their voice or threatening Alex. Taylor reported that Alex left the meeting early. The memorandum does not resolve the difference between this account and Alex's September 21 account.

Job demands

The customer-support role involves reading customer messages, sustained attention, switching between queues, and meeting response deadlines. This memorandum does not offer a diagnosis or medical work-capacity opinion.

SYNTHETIC DATA ONLY - No real patient, clinician, employer, or clinical advice.

Medication follow-up note

Subject: Alex Demo (entirely fictional)

Document / encounter date: September 29, 2026

Author: Dr. Rowan Example, primary care (fictional)

Medication history

Alex reported starting sertraline 25 mg daily on September 22, 2026, prescribed by an outside clinician. The outside prescribing note was not supplied. Alex reported mild nausea after starting the medication. These are patient reports, not independently verified prescribing records.

Symptoms and plan

Alex reported continued sleep disturbance and concentration difficulty. The clinician documented a plan to obtain the prescribing record and advised follow-up with the prescribing clinician. No medication change is documented in this note.

Scope

This fictional note illustrates attribution and a missing source record. It is not treatment guidance.

SYNTHETIC DATA ONLY - No real patient, clinician, employer, or clinical advice.

Psychotherapy progress note

Subject: Alex Demo (entirely fictional)

Document / encounter date: October 6, 2026

Author: Dr. Mira Example, psychologist (fictional)

Session report

Alex reported sleeping about six hours nightly but continuing to lose track of longer customer messages. Alex stated, "I attended every scheduled shift from September 28 through October 2." No attendance record was available at this session.

Observations and treatment

The clinician observed calm behavior and coherent thought during the session. The session addressed coping strategies and a consistent sleep routine. Weekly therapy was continued.

Limits

The note does not reassess the earlier temporary work-schedule recommendation. Medication response was not assessed. The workplace meeting description was copied from the September 21 intake for context; this repetition is not a new independent account.

SYNTHETIC DATA ONLY - No real patient, clinician, employer, or clinical advice.

Employer attendance memorandum

Subject: Alex Demo (entirely fictional)

Document / encounter date: October 8, 2026

Author: Taylor Example, supervisor at Example Services (fictional)

Attendance account

Taylor reported that the attendance log marked Alex absent for scheduled shifts on September 30 and October 2, 2026. The underlying time-clock entries and any schedule amendments were not attached.

Limits and dates

This memorandum was written October 8 and concerns the week September 28 through October 2. It does not explain the difference from Alex's October 6 statement that all scheduled shifts were attended. The reason for the absences and whether the schedule had changed are not established by the supplied records.

SYNTHETIC DATA ONLY - No real patient, clinician, employer, or clinical advice.

Psychological screening note

Subject: Alex Demo (entirely fictional)

Document / encounter date: October 12, 2026

Author: Dr. Mira Example, psychologist (fictional)

Reported result

The clinician recorded a PHQ-9 total score of 8. The completed item-level response sheet was not included in this packet. No proprietary test items or test materials are reproduced here.

Limits

No performance-validity or symptom-validity testing was documented. The clinician did not make a malingering determination, permanent impairment rating, or causation opinion in this note. The reported score should remain attributed to this source; it is not a newly administered assessment.

SYNTHETIC DATA ONLY - No real patient, clinician, employer, or clinical advice.

Psychotherapy follow-up note

Subject: Alex Demo (entirely fictional)

Document / encounter date: October 20, 2026

Author: Dr. Mira Example, psychologist (fictional)

Interval report

Alex reported sleeping six to seven hours nightly and taking short walks again. Alex continued to report difficulty concentrating during longer work tasks and needing extra time for household paperwork.

Outstanding information

The 2021 counseling records, outside prescribing note, underlying time-clock entries, and completed screening response sheet remained unavailable to this clinician. The supplied record does not settle the conflicting meeting or attendance accounts.

Plan and scope

Weekly psychotherapy was continued. No updated work-capacity determination was documented. No diagnosis, causation allocation, permanent impairment opinion, or credibility conclusion should be inferred beyond what the supplied authors actually recorded.

SYNTHETIC DATA ONLY - No real patient, clinician, employer, or clinical advice.