Andres Hernandez

H&P #3 – Psychiatry

Identifying Data:
Full Name: A.M.
Address: Queens, NY
Date of Birth: 11/19/2008
Age: 15
Date: 4/18/2024, 2:00 pm
Location: Queens Hospital Center Psychiatric Emergency Room
Religion: Unspecified
Marital Status: Single
Source of Information: Self
Reliability: Reliable
Source of Referral: Self
Mode of Transport: Mother

CC: “Missing school” x last 2-3 weeks.

HPI:
15 y/o male, domiciled with mother, stepfather, 7 y/o brother, grandmother and uncle, attending high school in the 10th grade, no past medical history or psychiatric history, is brought in by mother, for psychiatric evaluation after mother received call from school yesterday. Prior records were reviewed including previous documentation, labs, orders and medications.
evaluation pt appeared guarded, with blunted affect, sad, fidgety, poor eye contact, and hesitant when answering questions. Pt states he was brought in by his mother secondary to his school requesting evaluation. Pt admits he has not been going to school x weeks - began to stop going to school right before spring break. Pt states that because he has missed so much school, he is currently failing 4 classes. When inquired why pt has been missing school, pt requested hat the information be obtained from his mother. Pt admits he has seen a school therapist prior, but has not seen therapist recently due to his absenteeism from school. He stated that he has friends at school, is not bullied, and enjoys playing outside with his younger brother. Pt aspires to become an electrician and hopes to return to school. Pt denies homicidal ideation, or auditory and visual hallucinations. Pt denies any illicit substance or ETOH use. Pt admits he texted his mother that he "did not want to be here anymore" yesterday, and when writer asked pt what he meant by that pt explained that he did not want to be alive. Pt denies any suicidal plan but admits he has thought about "not being here" frequently, especially when he is lonely. Pt denies any past suicidal attempts or self injurious behavior. Pt denies taking any past psychiatric medications, or past psychiatric hospitalizations.
Collateral information was obtained from pt’s mother, who endorses she received a call from the school yesterday reporting pt’s absence from class. Mother states she was under the impression that he was attending classes but always left before pt to drop off her other child to daycare/school. Mother asked pt. to explain his behavior, and he admitted to feeling sad, lonely, and how he felt like he doesn't fit in at school, expressing thoughts that his family would be better off without him. Mother noted a recent change in pt's behavior and temperament, describing him as irritable, explosive, rude, and more angry in the past 3 months. She denied that pt. is isolating himself. Mother attributed these changes to a strained relationship with pt's

biological father, who is separated from her. She mentioned that the father had made several promises to contact Adrian but failed to do so, leading pt to express, "I do not have a father." Additionally, pt was deeply saddened by the recent death of his cousin in Ecuador and missed school during that period.
Patient currently exhibits impaired insight, poor judgement and impulse control and appears acutely depressed and is a possible danger to himself. At this time based upon current presentation of acute depressive features and pt continuing to endorse suicidal ideations with no plan, patient warrants behavioral observation and stabilization in EELOS. Disposition to remain in EELOS discussed with patient who agrees at this time. Maintain 1:1 observation for elopement risk and unpredictable behavior. Re-eval in AM by child psychiatrist.
Case discussed with attending psychiatrist, who agrees with assessment and plan.

Past Psychiatric History:
-No past psychiatric history.

Past Medical History:
-No past medical history.
-Denies childhood illnesses.
-Immunizations up to date.

Past Surgical History:
-No past surgical history.
-Denies blood transfusions and past injuries.

Medications:
-No medication use.

Allergies:
-none

Family History:
Mother- alive and healthy.
Father – alive and healthy.
No pertinent family history.

Social History:
Patient lives with mother, brother, step father, uncle, and grandmother.
Habits- denies alcohol, caffeine use, drug use.
Relationship status – single.
Sleep – unknown was not asked.
Appetite - unknown was not asked.
Exercise- plays outside with brother.
Past arrest/incarceration history – none

ROS:
General – Denies insomnia, recent weight loss, generalized weakness/fatigue, fever or chills, or

night sweats.

Eyes – Denies photophobia, visual disturbances, lacrimation, pruritus, or use of contact lenses.

Ears – Denies deafness, pain, discharge, tinnitus, or use of hearing aids.

Pulmonary System - Denies shortness of breath or cough.

Cardiovascular System - Denies chest pain, HTN, palpitations.

Gastrointestinal system – Denies abdominal pain, and nausea.

Genitourinary system – Denies urinary frequency or urgency, nocturia, oliguria, polyuria, dysuria, incontinence, awakening at night to urinate or flank pain.

Nervous – Denies seizures, headache, dizziness, speech change, or weakness.

Endocrine system – Denies polyuria, polydipsia, polyphagia, heat or cold intolerance, excessive sweating, hirsutism, or goiter.

Psychiatric –Ha sno history of depression, anxiety. Denies suicidal ideation attempt, homicidal thoughts, hallucinations, seeing a therapist.

Physical exam:
General: Young male, appears her stated age, height and weight, awake, fairly groomed, alert and oriented x 3, in no acute distress, responds quickly to questions, has good color. Can ambulate without assistance.

Vital signs:
BP: 128/76 mm Hg (BP location: Right arm)
R: 18 breaths/min, unlabored
P: 86 beats/min, regular
T: 98.7 degrees F (oral)
O2 Sat: 99% room air
Height: 1.651 m (5’5”) Weight: 48.1 kg (121 lb) BMI: 20.1 kg/m2

Mental Status Exam:
General
1. Appearance: Patient is alert, casually groomed, well-nourished.
2. Behavior and Psychomotor Activity: Patient is guarded and avoiding eye-contact.
3. Attitude Towards Examiner: Patient is cooperative during the interview.

Sensorium and Cognition
1. Alertness and Consciousness: The patient was conscious and alert throughout the interview.
2. Orientation: Patent was oriented to the date, place, and time of the interview.
3. Concentration and Attention: Good concentration and unimpaired memory.

4. Capacity to read and write: Patient can read and write.
5. Abstract thinking: Proper ability to abstract think.
6. Memory: Memory was unimpaired.
7. Fund of information and knowledge: patient's intellectual performance consistent with level of education.

Mood and Affect
1. Mood: Anxious, Sad/Depressed.
2. Affect: Blunted affect appropriate with mood.
3. Appropriateness: Mood and Affect were congruent throughout the interview.

Motor
1. Speech: Patient's speech is soft and monotonous.
2. Eye Contact: Patient is avoiding making eye contact.
3. Body Movements: No psychomotor abnormalities

Reasoning and Control
1. Impulse Control: Fair impulse control. Patient denies any suicidal ideations and plans.
2. Judgement: Patient had fair judgement based on appreciating consequences of actions.
3. Insight: Patient has fair insight into his psychiatric condition.

Assessment:
An 15-year-old Hispanic male, with no past medical or psychiatric history is brought to the psychiatric emergency room by his mother for psychiatric evaluation following a call mother received from school regarding patient recent absences. Upon evaluation the patient appeared guarded, with blunted affect, sad, fidgety, poor eye contact, and hesitant when answering a question. Patients currently exhibit impaired insight, judgement, impulse control, and appear to be depressed. Patient has suicidal ideations with no plan and warrants behavioral observation and stabilization. Maintain 1:1 observation for unpredictable behavior and re-evaluate in the morning by child psychiatrist.

Differential Diagnosis:
1. Unipolar major depression — Unipolar major depression (major depressive disorder) is characterized by a history of one or more major depressive episodes and no history of mania or hypomania. Child or adolescent must display at least five of the depressive symptoms for at least two weeks; at least one of the symptoms is either dysphoria or anhedonia.

2. Adjustment disorder – Adjustment disorder with depressed mood is marked by depression that occurs in response to an identifiable psychosocial stressor. The stressor may be a single event or there may be multiple stressors. Adjustment disorder with depressed mood is not classified as a depressive disorder. The syndrome does not meet criteria for another psychiatric disorder such as major depression. Therefore, adjustment disorder describes patients suffering significant symptoms that do not meet criteria for a more specific psychiatric disorder.

3.Substance induced depressive disorder – Substance induced depressive disorder consists of a mood disturbance that is characterized by a persistently depressed or irritable mood, or diminished interest or pleasure in most activities that develops during or soon after using

substances (eg, alcohol, cocaine, opiates, and amphetamines). In addition, the disturbance causes significant distress or impairs psychosocial functioning.

4.Bipolar – Episodes of major depression occur in both unipolar major depression (major depressive disorder) and bipolar disorder; however, patients with bipolar disorder have a prior history of manic/hypomanic episodes, whereas patients with unipolar major depression do not. However, bipolar disorder is frequently misdiagnosed as unipolar major depression because the mood episode at onset of bipolar disorder is often a depressive and multiple episodes of major depression may occur prior to the first lifetime episode of mania or hypomania and also the depressive symptoms will occur more frequently than mood elevated symptoms.

5.Sadness – sadness and irritability (dysphoria) in the absence of other symptoms do not result in a diagnosis of a depressive disorder. As an example, the diagnosis of unipolar major depression requires not only that the dysphoria occurs for most of the day for nearly every day for at least two weeks, but that the dysphoria is accompanied by at least four other depressive symptoms as well as significant distress or psychosocial impairment. Sadness and irritability are a normal, adaptive part of the human condition, particularly in response to loss, disappointment, or perceived failure. Patients with other psychiatric conditions, such as anxiety disorders, attention deficit hyperactivity disorder (ADHD), disruptive behavior disorders, substance use disorders, and eating disorders can experience sadness in their own ways.

Plan:
-Keep patient overnight on 1:1 observation for unpredictable behavior.
-Reassess in the morning for suicidal ideation, intent, or plan.
-Discuss treatment plan with mother and patient to consider therapy to open about feelings more.
-Refer patient to Child Crisis Special to further assist with outpatient management options.