History & Physical

Identifying Data:
Full Name: AG
Address: Queens, NY
Date & Time: March 8th, 2020 1:10 PM
Location: Queens Hospital Center – CPEP
Religion: Unknown
Source of Information: Self, Reliability Good
Source of Referral: Parents

Chief Complaint: "I just can't cope with all the pressure at school"

History of Present Illness:
16 y/o Caucasian female, high school student in 10th grade, domiciled with family (mother, father, and two younger brothers) with no reported past psych hx, with no reported PMHx, brought in by family who were concerned with her recent weight loss, decreased appetite, lack of sleep, and suicidal ideation.
Patient was seen in CPEP interviewed in private, then with mother present. Patient was cooperative, and appeared very depressed with anhedonia, anergia. Patient stated she broke up with her boyfriend about 6 weeks ago and since that time she has not slept more than 4-5 hrs a night. Also reports an unintended 15lb weight loss with decreased appetite. She states that nothing interests her and she is unable to concentrate at home or at school. She has low energy and not hanging out with friends like she was in the past. She states that when she's with her friends "things are just not fun anymore." She is slightly irritable and annoyed with questioning. She admits to hearing a voice that tells her that she is "no good." States she has her the voices intermittently for last 1-2 weeks but daily for the last week. She also admits to suicidal ideation over the last few days, but denies she would act on them because it is a "sin." She denies having a suicide plan. She denies any HI/VH, paranoia, or delusions. Pt denies taking any psychiatric medication or known psych history. She also denies any alcohol, smoking, and substance use. Her mother A.A (718-123-4567) states that patient is usually a happy, cheerful, obedient, and good student. However lately she has been depressed, barely sleeping or eating. and at first her and her husband have been giving patient space to cope with recent breakup but has been growingly concerned especially with grades dropping. Mother states that both her and husband works a lot and depends on her daughter to take care of household chores and her siblings. Mother denies knowing about patient's suicidal ideation and AH.

Past Medical History:
Patient denies any past medical Hx.

Past Surgical History:
Denies any surgeries.

Medications:
Benadryl prn for seasonal allergies.

Daily Multivitamins.
Denies any herbal use.

Allergies:
Seasonal allergies.
Denies other drug or food allergies.

Family History:
Denies family hx of any psychiatric disorders.

Social History:
Patient is an Italian-American 10th grader at York High School, gets good grades in the 90's, and lives with her mother, father, 12 and 10 y/o brothers. She states her friends are good support but recently lacks any interest in "hanging out with them." Pt was happy prior to breakup that occurred 6 weeks ago. She admits to lack of appetite or interest in eating and decreased sleep. Patient denies smoking cigarettes, drinking alcohol, elicit drug use, and regular exercise. Patient denies a history of abuse, neglect, or trauma.
Mother reports she is unsure what is going on with the patient because she sees the patient as a happy young girl and she gets along well with her siblings.

Review of Systems: Psychiatric
Admits: feelings of depression/sadness, insomnia, auditory hallucinations.
Denies: excessive sleep, disorientation, mood extremes, visual hallucinations, delusions, anxiety, OCD or seeing a mental health professional.

Physical Examination

General: 16 y/o Italian-American female is A&O x3, in no apparent distress, neatly groomed, well dressed, good hygiene, well-developed, skinny frame, slouched posture, and appears her stated age.

Mental Status Exam
Observations:

1. *Appearance*: AG is a average height and small build and alert throughout interview. She appeared well-developed, slouched posture, and appeared her stated age. Her hygienic state was appropriate and clean. She had no scars or atypical body features. She was wearing a light blue top with jeans, and had a necklace/ring on. Her body movements were purposeful and not excessive. She had normal gait and station.

2. *Attitude Towards Examiner*: AG was shy at first but eventually started saying more when asked questions. She was cooperative during the examination and I was able to establish rapport for the purposes of the interview.

3. *Behavior*: AG seldomly fidgeted for most of the interview usually by playing with her hair. Patient appeared calm but guarded. Her head was stooped down and her eyes did not look up much, poor eye contact throughout the interview even when her mother was

present.

4. Speech: AG speech was slow-normal rate, monotone, soft/normal volume, nomal latency, and fluent.

Emotions:

1. *Mood*: AG mood was a combination of dysphoric, and depressed. Her her head was down a lot and she was not smiling much. "feel pressure in life"

2. *Affect*: AG's affect was depressed, sad, and constricted. Her mood and affect were congruent and relevant to the conversation.

Thoughts & Perceptions Thought Process

1. Thought process: AG's thought process was logical and coherant. It is not goal directed, wants to go home, interest in dancing. No abnormal thought patterns exhibited.
2. Thought content: AG has expressed thoughts of suicidal ideation with no plan.
3. Perceptions: AG expressed previous auditory hallucinations at home telling her she was "no good." None exhibited during interview.

Cognition:

1. *Orientation*: AG was oriented to person, place of the exam, and the date. AG was alert and her level of consciousness did not change throughout the interview.

2. *Concentration and Attention*: AG had normal ability to concentrate on any directions throughout the interview, and was able to spell WORLD forward and backword. Although sometimes distracted by another patient that was loud in the unit.

3. *Memory*: AG's recent, remote, and immediate memory were intact as she was able to recall her breakfast, previous relationship, her friends, siblings and what transpired before coming today. AG intellectual performance was consistent with her level of education (10^{th} grade). She had good knowledge of current and past events as she was able to say the world won't last much longer because "bad things keep happening like the fires in Australia."

Insight and Judgement:

1. *Insight:* AG has poor insight into her present condition. When asked if she would harm himself after this, she said "no because it is a sin." She did not seem to think it was wrong.

2. *Judgment*: AG's judgement is impaired. When suggesting she may have an impact on the world when she grows up and goes to college, she said "the world might be better off without me" She also admits to auditory hallucinations of someone telling her "I'm not good enough."

Assessment:
16 y/o Caucasian female, high school student in 10th grade, domiciled with family (mother, father, and two younger brothers) with no reported past psych hx, with no reported PMHx, brought in by family who were concerned with her recent weight loss, decreased appetite, lack of sleep.

Differential Dx:
Major Depressive disorder with mood congruent psychotic feature (AH)
Schizoaffective disorder
Adjustment Disorder
Bipolar disorder

Plan:
1) Start on Prozac 10mg PO QD for major depressive disorder
2) Admit for observation with parental consent or discuss safety contract
3) Complete blood work as directed
4) Refer to QHC's Child & Adolescent Psychiatry for f/u

At this time, patient is obviously quite depressed, reporting SI and AH, but deemed not to be in imminent danger to herself or others. Pt is in need of further psychiatric evaluation and recommended admission for observation and re-evaluation in the morning by child psychiatry. Patient is to be given a follow up appointment at QHC at Child & Adolescent Psychiatry upon d/c. Case discussed with attending doctor.

Differential Dx:

Major Depressive Disorder: the patient exhibits > 5 depression symptoms, which have been present for 2 weeks.

Schizoaffective disorder: includes both depressive and psychotic symptoms. The patient exhibits most common auditory hallucination, and lack of motivation and disinterest. Possibly need more history.

Adjustment Disorder: the patient may be having an emotional or behavioral reaction to recent breakup. She has marked distress out of proportion (insomina, weight loss) and unable to concentrate in school or have social interaction. However least likely due to patient exhibiting vegetative symptoms and SI/AH.

Bipolar disorder: the patient may be experiencing several episodes of depression before the first onset of mania. Although less likely given history and no exhibited manic state, just wanted to be cognizant of differential.