Jeleeta Jolly
June 15, 2026
Rotation #5: Psychiatry at Queens Hospital Center

H&P 1 - Psychiatry

Identifying Data:
Full name: K.C.
Address: Jamaica, NY
Location: Queens Hospital Center
Source of information: Self and Collateral
Source of referral: Patient's mother

Chief Complaint: Suicidal Ideations

History of Present Illness:

Patient K.C. is a 20 year old Pakistani female, current college student, domiciled with mother and siblings, with reported history of depressive and anxiety disorder secondary to medical condition of muscular dystrophy (wheelchair-bound) who presents to CPEP brought in by EMS after calling 911 for passive suicidal ideation, requesting stabilization. She reports worsening anxiety, restlessness, and depressed mood related to her physical limitations from muscular dystrophy. Patient states she has been ruminating often, experiencing difficulty with sleep and poor appetite due to anxiety. She states she first noticed these symptoms about 3 months ago and recently began seeing an outpatient psychiatrist for an initial appointment one month ago, who started her on Celexa 10mg daily and Xanax prn, however she feels they have increased her anxiety symptoms. Patient admits to passive suicidal ideation but denies plan, intent, or prior suicide or self-harm attempts. She denies feelings of hopelessness, helplessness, homicidal ideations, auditory or visual hallucinations, paranoia, delusions, manic or psychotic symptoms, prior psychiatric hospitalizations, history of trauma or abuse, substance use or abuse, or any known family psychiatric history. She denies alcohol or illicit drug use.

Collateral information obtained from patient's mother who reports worsening depression, anxiety, and decreased appetite in recent days, and endorses patient has made comments about not wanting to live anymore, but denies any attempt or self-harm behaviors. Mother believes physical limitations from muscular dystrophy are the main reason for patient's depression and anxiety symptoms. Patient is a college student studying marketing. She identifies her mother as her primary source of emotional support, but denies other sources of support in the community.

Past Medical History
No significant past medical history.
Immunization: Up to date per chart review.

Past Surgical History
No significant past surgical history.

Medications
Mirtazapine 7.5 mg tablet (given in CPEP)
Celexa 10 mg daily
Xanax 0.25 mg as needed

Allergies:
No seasonal or food allergies.
NKDA

Family History
Mother, alive at 50, no PMH
Father, alive at 53, diabetes, HTN
Grandparents, (ages uncertain), uncertain of PMHx
Siblings, 1 sister and brother, living and well

Social History
Habits: Denies alcohol use, smoking, drinking coffee or usage of illicit drugs.
Travel: Denies travel outside the country.
Sexual history: Pt is not currently sexually active. Pt denies hx of past STIs. Denies use of barrier methods or contraceptives.

Review of Systems:
General: **Admits to decreased appetite and difficulty falling asleep**. Denies fevers, chills, recent weight loss or weight gain, generalized weakness/fatigue, or night sweats.
Skin, hair, nails: Denies rashes or bruises.
HEENT: Denies headache, visual disturbances, deafness, nasal discharge, or sore throat.
Neck: Denies localized swelling/lumps or stiffness.
Pulmonary System: Denies cough or shortness of breath.
Cardiovascular System: Denies chest pain.
Gastrointestinal System: Denies abdominal pain, nausea, vomiting, constipation, or diarrhea.
Genitourinary System: Denies frequency, nocturia, urgency, hematuria, or dysuria.
Nervous System: Denies seizures, headache, loss of consciousness, sensory disturbances, or change in cognition/mental status/memory.
Musculoskeletal System: Denies muscle/joint pain or deformity.
Psychiatric: **Admits to depression, mild suicidal ideation/ thoughts, and anxiety.** Denies feelings of helplessness, feelings of hopelessness, lack of interest in usual activities, auditory or visual hallucinations, homicidal ideation, or obsessive/compulsive disorder.

Physical Exam

General: 20 y/o female, well groomed, in no apparent distress. Patient was found dressed in hospital gown, sitting in wheelchair, A&O x 3.

Vital Signs:

BP:	100/66 mm/Hg	
RR:	18 breaths/min, unlabored	
P:	101 beats/min, regular	
T:	98.2°F, oral	
SpO2	98% room air	
Ht: 5'1"	Wt: 80 lbs	BMI: 15.13

Skin: No scars, rashes, or bruises.
Psychiatric: Patient appears calm and cooperative but with poor eye contact. Speech is slowed but coherent, with some latency. Mood is described as "okay" with blunted affect. Thought process is linear and goal-directed. Thought content notable for passive suicidal ideation, with no plan or intent. Denies homicidal ideation, auditory or visual hallucinations. Cognition is grossly normal. Insight and judgement are impaired with impulse control fair at this time.

Mental Status Exam
General

1. **Appearance:** Patient is a 20 year old Pakistani female, slim, appearing as stated age. She is dressed in hospital gown, seated in wheelchair, well-groomed, with good hygiene. No visible scars, lesions, or marks noted on face or hands. She appears in no acute distress.
2. **Behavior and Psychomotor Activity**: Patient remains calm throughout the interview. Responses are at adequate speed and appropriate. No tremors or involuntary movements were present.
3. **Attitude towards Examiner**: Patient is cooperative and engaging in conversation. Rapport was established easily.

Sensorium and Cognition

1. **Alertness and Consciousness**: Patient is alert and conscious throughout the interview.
2. **Orientation**: Patient is oriented to person, place, and time.
3. **Concentration and Attention**: Attention and concentration were intact. Responses were goal directed.
4. **Capacity to Read and Write**: Not assessed during this interview.

5. **Abstract Thinking**: Patient appears intact, ability to interpret proverbs was not tested.
6. **Memory**: Patient's recent and remote memory remains intact.
7. **Fund of Information and Knowledge**: Fund of knowledge appeared appropriate for age, education, and background.

Mood and Affect

1. **Mood**: Patient described her mood as "okay".
2. **Affect**: Patient's affect is blunted, with reduced emotion throughout the interview.
3. **Appropriateness**: Mood and affect were appropriate to the content discussed. No labile emotions or inappropriate affect was observed.

Motor

1. **Speech**: Patient's speech is slow, soft, and quiet, with some latency in responses. Speech is coherent, understandable, and goal-oriented.
2. **Eye Contact**: Patient maintained limited eye contact throughout the interview, primarily looking down.
3. **Body Movements**: Patient exhibited mild psychomotor slowing. No abnormal involuntary movements were observed.

Reasoning and Control

1. **Impulse Control**: Patient's impulse control is fair at this time, as she denies intent to act on suicidal thoughts.
2. **Judgement**: Patient has impaired judgement in the context of ongoing depressive and anxiety symptoms, with suicidal ideation.
3. **Insight**: Patient has impaired insight into the severity of her condition and the need for ongoing treatment, though she has had an appointment with outpatient psychiatry one month ago.

Problem List:

- Hx of depression
- Hx of anxiety disorder
- Muscular dystrophy
- Suicidal ideation
- Anxiety
- Insomnia

Assessment: 20 year old Pakistani female, domiciled with family, with reported history of depressive and anxiety disorder due to medical condition brought in by EMS secondary to passive suicidal ideation. She reports recent worsening anxiety, restlessness, and depressed mood. She also endorses difficulty with sleep and poor appetite due to anxiety. At this time, she endorses passive suicidal ideation but with no plan or intent. She denies any history of prior suicide attempts. Her presentation is further exacerbated by her medical condition of muscular dystrophy, which the patient's mother believes is the main reason for her symptoms. On

evaluation, patient appeared cooperative, but with a depressed mood and blunted affect. She had poor eye contact, spoke soft and slowly, with impaired judgement and insight. Given patient's passive suicidal ideation, recent worsening depressive and anxiety symptoms, and collateral concern and request for stabilization, patient will be admitted to CPEP for observation and stabilization to rule out substance induced symptoms and for continued safety monitoring.

Differential Diagnoses:

1. Major depressive disorder

   This diagnosis is likely given the three month history of depressed mood, poor appetite, sleep disturbance, passive suicidal ideation, and decreased quality of life related to her chronic medical illness. Although she denies feelings of hopelessness and has preserved future orientation as a college student, she demonstrates several symptoms consistent with a depressive episode. Her mother's collateral report of worsening depression and comments about not wanting to live further support the presence of clinically significant depressive symptoms. While her medical condition contributes to her emotional burden, the clinical picture is most consistent with MDD because she demonstrates several depressive symptoms that extend beyond an expected emotional reaction to illness.
2. Anxiety disorder due to known physiological condition

   This should be considered due to the patient's persistent anxiety, excessive rumination, restlessness, insomnia, poor appetite, and difficulty controlling worry. Her anxiety appears to extend beyond isolated situations and has significantly impaired her daily functioning. The chronic nature of her medical condition and uncertainty regarding her future may contribute to worry that is characteristic of anxiety disorder.
3. Adjustment disorder

   This is also highly likely given the clear relationship between her emotional distress and the burden of muscular dystrophy and its associated physical limitations. The patient's symptoms appear closely tied to ongoing stressors involving loss of independence, wheelchair dependence, and limited social support. Her symptoms may represent a maladaptive response to chronic life stress.
4. Depressive disorder secondary to medical condition

   Given her longstanding diagnosis of muscular dystrophy, depressive symptoms secondary to her medical condition is most likely the diagnosis. Chronic progressive illnesses are associated with increased rates of depression. The patient's physical disability, functional limitations, and dependence on others are likely contributing to her mood symptoms. In this case, her depression appears

more related to the psychological and functional impact of living with muscular dystrophy rather than a direct effect of the disease.

5. Medication induced anxiety disorder

   This diagnosis should also be considered, although less likely to explain the full clinical situation. The patient reports that her anxiety worsened after recently starting Celexa. Early SSRI treatment can cause increased anxiety, restlessness, agitation or insomnia, especially within the first few weeks of treatment. While her depressive and anxiety symptoms began before the start of taking SSRI, this could be exacerbating her current presentation.

Workup/Plan:

- Admit to CPEP under New York Mental Hygiene Law 9.40 for observation and stabilization given suicidal ideation with impaired judgement and safety concerns.
- Start Q15 safety checks in CPEP to monitor for suicidal thoughts, self harm behaviors, or other behavioral changes
- Provide supportive therapy, psychoeducation, and crisis intervention as indicated.
- Encourage participation in individual, group, and milieu therapy while in CPEP
- Medication management
    - Start patient on Zoloft 25 mg orally daily.
    - Give mirtazepine 7.5 mg at bedtime for restlessness/insomnia management. Doses will need to be titrated in the next few weeks based on presenting symptoms and therapeutic benefit.
    - Assess patient's response to medication (improvment in sleep, suicidal ideation, anxiety symptoms)
- Obtain ongoing collateral information from family as needed
- Obtain labs (CBC, CMP, quantitative hCG, serum ethanol, UA, and TSH) to rule out medical causes of symptoms
- Obtain urine toxicology screen (5-panel) to rule out substance induced symptoms
- Follow up labs and medical follow up as needed and substance abuse counseling if needed pending urine toxicology drug screen

Patient Education

- Encouraged regular diet due to low BMI (15.13)
- Provided psychoeducation regarding depression, anxiety, and suicide and the role of psychotherapy and medication management in symptoms improvement
- Arrange outpatient psychiatry and therapy follow up prior to discharge to ensure continuity of care and ongoing support

/s/ Jeleeta Jolly, PA Student