Lily Fremaux
Psychiatric Rotation
H&P 1
05/07/2026

Name: C.R.
DOB: 07/21/2002
MRN: #######
Location: Metropolitan- NYC Health and Hospitals
Date of Service: 03/26/2026
Source of information: Self
Reliability: Reliable
Address: Bronx, NY

HPI:
24 y/o male with a PMHx of HIV (on ART, adherence unclear) and prior psychiatric treatment (details unclear) who was seen in Weill Cornell ED earlier today and discharged with instructions to presents to outpatient mental health clinic at Metropolitan Hospital now here for evaluation of worsening perceptual disturbances and paranoia x2-3 weeks. Patient reports progressively worsening symptoms, including seeing “faces that don’t look real” and hearing voices that say “lets mess with him.” He endorses increasing paranoia, stating he feels like people are watching or following him. He also reports a markedly decreased need for sleep, sleeping 1–2 hours per night over the past week with increased energy, restlessness, and difficulty sitting still. He reports poor appetite with intermittent nausea but denies significant weight loss. Patient recently relocated from Mississippi and has been in New York for approximately 10 months. He reports a prior history of psychiatric treatment but is unable to recall prior diagnoses, medication names, or duration of treatment. When asked if he had experienced these symptoms before, patient states that he is unsure. Substance use history is notable for methamphetamine use. Denies IVDU, reports that he smokes methamphetamines. Patient provides inconsistent history regarding recent use. He initially denies recent use but later states possible use within the past several days. When ask if patient has these symptoms after using methamphetamines or when not using, patient says he is unsure and is not able to clarify. At ED, patient endorsed similar symptoms, denied any SI/HI, was deemed to not meet criteria for inpatient treatment, and was agreeable to come to Metropolitan Clinic to establish care. Urine toxicology obtained in the ED earlier today was positive for amphetamines. Here in the clinic, denies suicidal or homicidal ideation, intent, or plan. He expresses distress regarding his symptoms and is motivated for treatment, stating he just wants his symptoms to “go away.” Patient states that he has a PCP and is on ART but says he sometimes forgets to take his medication and does not know name or location of PCP. Is open to having PCP here at metropolitan. Patient also expresses desire to stop using methamphetamines and is open to support doing so. Collateral information is not available at this time.
PMHx: HIV
Past Psychiatric History: Unclear
PSHx: Denies

Allergies: NKDA, denies
Meds: ART, compliance unclear
Social:

- Endorses methamphetamine use and daily cigarette use (5 cigarettes a day for the past 4 years).
- Endorses having three cocktails on the weekends.
- Has HASA housing (HIV/AIDS Services Administration)Currently unemployed

States that he is not currently sexually active, but reports multiple same-sex partners in the past years with barrier protection.

ROS:
General: Endorses decreased appetite. Denies weight loss.
Psychiatric: Positive auditory hallucinations, visual disturbances (seeing faces), paranoia, and decreased sleep. Denies SI/HI.
GI: Endorses nausea.

Mental Status Exam:
Appearance: Appears stated age, adequately groomed and dressed, good hygiene
Gait: Normal
Behavior: Cooperative, intermittently guarded, maintains eye contact but occasionally scans surroundings
Psychomotor: Mild psychomotor agitation noted, fidgeting and shifting in seat, no abnormal involuntary movements
Speech: Spontaneous, normal volume, mildly increased rate at times, non-pressured
Thought Process: Circumstantial with occasional tangentiality, generally redirectable
Thought Content: Paranoid delusions (belief that others are watching or following him), no overt grandiosity
Mood: “On edge,” dysphoric
Affect: Anxious appearing, constricted, congruent with mood
Perception: Endorses auditory hallucinations (voices commenting on him) and visual perceptual disturbances (“faces that don’t look real”)
Attention/Concentration: Mildly impaired; occasionally requires redirection during interview
Suicidality: Denies suicidal ideation, plan, or intent
Homicidality: Denies homicidal ideation, plan, or intent
Insight: Poor
Judgment: Poor
Impulse Control: Fair

Assessment:
24 y/o male with a PMHx of HIV (on ART, adherence unclear) and prior psychiatric treatment (details unclear) presents to evaluation of worsening perceptual disturbances and paranoia x2-3 weeks. Patient endorsing auditory hallucinations along with visual disturbances and paranoia. Denies SI/HI at this time. Presentation is most consistent with substance-induced psychotic disorder. Also consider primary psychotic disorder/schizophrenia, Bipolar I disorder (current

manic episode with psychotic features), psychotic disorder due to HIV or other medical condition, or unspecified psychotic disorder).

DDx:

1. Substance-Induced Psychotic Disorder
    - Patient with a known history of methamphetamine use and a positive Utox.
    - With classic symptoms including paranoia, auditory hallucinations, and visual disturbances
    - However, with inconsistent timeline of use and unclear if symptoms occur during abstinence from methamphetamine use, cannot fully exclude primary psychotic disorder
2. Primary Psychotic Disorder/Schizophrenia
    - Age (24 years old) typical of acute-onset of schizophrenia
    - Has positive symptoms including hallucinations or paranoia
    - Also has prior psychiatric treatment, though unclear
    - Less clear due to substance use
3. Bipolar I Disorder, Current Episode Manic with Psychotic Features
    - Supporting symptoms including markedly decreased need for sleep, increased energy, and restlessness
    - Psychotic features (voices, paranoia) can occur in severe mania
    - Unclear history of prior mood episode and substance use limits this diagnosis
4. Psychotic Disorder Due to Another Medical Condition (HIV)
    - HIV with unclear ART adherence. Could be HIV-associated neurocognitive or psychiatric manifestation
    - Less likely given no clear cognitive decline or acute neurologic symptoms reported
5. Unspecified Psychotic Disorder
    - Given limited psychiatric history, no collateral information, and competing etiologies of substance induced vs primary psychotic disorder can serve as working diagnosis until further information obtained.

Plan:

Olanzapine 5mg nightly (patient strongly agrees)
Baseline EKG
Basic labs (CBC, CMP)
CD4 count and HIV viral load
Utox
Refer to PCP here at metropolitan
Refer for psychotherapy here at metropolitan
Return to clinic in one week for evaluation or sooner if worsening symptoms