

Michael Tan

Metropolitan Inpatient Psychiatry 6W

Date: 1/30/26

H&P

### History of Present Illness:

█ is a 21-year-old male with a past psychiatric history significant for borderline personality disorder, seizures, major depressive disorder, multiple prior suicide attempts, self-harm behaviors, and impulse control difficulties, who self-presented to the psychiatric emergency department on 1/6/26 for suicidal ideation with a plan to jump off a roof or overdose on his prescribed Depakote. His most recent inpatient psychiatric admission was at Metropolitan Hospital from 12/2/25 to 12/9/25, at which time he was reportedly advised to return to the hospital if his symptoms worsened following discharge. The patient reported increased psychosocial stressors since Christmas, including ongoing physical abuse in his home environment. He endorsed worsening depressive and anxious symptoms in this context. Given the severity of his suicidal ideation, history of prior attempts, and current psychosocial stressors, he was admitted to the inpatient psychiatric unit for further evaluation, stabilization, and safety.

### Past medical history:

- Major depressive disorder with suicidal ideations
- Anxiety
- Seizures
- Borderline personality disorder (recently diagnosed)

### Allergies

- Shellfish-derived products/fish allergy
  - o Reaction: swelling, angioedema and anaphylaxis

### Past surgical history:

- Electroencephalogram with reactivity check awake and asleep (12/5/25)

### Medications:

#### Scheduled:

- Citalopram (Celexa) tablet 30 mg
- Divalproex (Depakote) tablet 1,000 mg
- Prazosin capsule 1 mg

#### As needed:

- Acetaminophen tablet 650 mg
- Haloperidol injection 5 mg
- Hydroxyzine tablet 50 mg
- Melatonin tablet 3 mg

- Olanzapine disintegrating tablet 10 mg

**Family history:**

- None

**Social history:**

Marital status: single

Housing situation: private residence with friend

Employment: unemployed

Smoking status: Yes

- Vaping an unspecified amount

Alcohol use: Yes

- Alcohol use an unspecified amount
- Denies history of withdrawal seizures

Drug use: Yes.

- Cannabis use (2 times a week)

**Psychiatric Review of systems:**

- depressed mood, sleep disturbance, feeling of hopelessness/guilt, suicidal ideation and concertation issues as per ED disposition note

**Physical:**

- Most recent Vital signs (1/30/26)
  - o Temperature (F): 97.2
  - o Heart rate: 80
  - o Respiration rate: 18
  - o Blood pressure: 138/80
  - o SpO2%: 100

**Imaging:**

- None

**Labs:**

**Valproic acid levels**

Date	1/6/26	1/21/26	1/28/26
Level	21.2	106.6	116.0

**Mental status exam:**

1. Appearance: Patient is a 21 y/o African American male, well groomed,

hygienic and well-kept in his personal pajamas, appears his stated age, in no acute distress. Patient is A&OX3 to person, place, and time.

2. Behavior and Psychomotor Activity: During one-to-one interview, patient presents with normal psychomotor activity; calm, sitting quietly, displaying purposeful movements. Slump posture. Maintain good and appropriate eye contact.

3. Attitude Towards Examiner: Patient cooperated with the examiner during the interview.

### **Sensorium and Cognition**

1. Alertness and Consciousness: The patient was conscious and alert during the entire interview

2. Orientation: Patient was oriented to person, the place of the exam and the time.

3. Concentration and Attention: Patient is alert and attentive. He can maintain focus throughout the interview. Concentration is intact. Not easily distracted in interview.

4. Capacity to Read and Write: Patient has fair capacity to read; in group activity therapy he can be seen writing and drawing. Patient was also given an information sheet on borderline personality disorder to educational purposes by treatment team.

5. Abstract Thinking: Patient can understand meaning of common proverbs such as “practice makes perfect”. He can perform simple mathematical calculations such as addition, subtraction and multiplication.

6. Memory: Patient’s remote and recent memory appears normal

7. Fund of Information and Knowledge: Patient’s intellectual performance was consistent with her level of education.

### **Mood and Affect**

1. Mood: The patient’s mood alternates between euthymic, euphoric and anxiousness during interviews. In some interviews, he is “happy” and “fantastic” and in others he is anxious or calm.

2. Affect: Congruent with mood during interviews. Full, appropriate and reactive.

3. Appropriateness: His mood and affect were consistent with the topics he discussed. He did not exhibit liable emotions or emotional outbursts.

### **Motor**

1. Speech: Speech is clear, coherent, no slurring.

2. Eye Contact: patient maintain constant eye contact with examiner throughout interview.

3. Body Movements: Patient displayed no abnormal movements or tremors during interviews. Gait is normal.

### **Reasoning and Control**

1. Impulse Control: patient impulse control was satisfactory during interview. He states not having suicidal or homicidal urges during the interview. Per the floor staff, patient would exhibit impulsive behaviors outside of interviews. There were incidences where patient would get into physical altercations with other patients on the floor as per floor nurse. In a previous interview, patient requested to be transferred into different room preferably with another male patient because he feels “lonely” sometimes.

3. Insight: patient has fair insight of his diagnosed psychiatric condition and is aware that it is an illness. An information sheet about borderline personality disorder has been given and reviewed with the patient. Per the patient, he states “this is exactly me” when treatment team reviewed and educated patient on borderline personality disorder during an interview.

## **Assessment**

Patient is a 21-year-old African American male with past medical history of major depressive disorder, multiple suicide attempts, impulsive control issues, seizures, self-harm behaviors and borderline personality disorder. She was initially brought into the ED for suicide attempt with a plan to either jump off a roof or overdose on his prescribed Depakote. In today's interview, patient presents as well kept in personal clothing, in no acute distress, and A&Ox3 to person, place and time. He denies feelings of depression, hallucinations, suicidal and homicidal ideations. He states he is taking his medications and denies any complications with them. Treatment team's plan for the patient is continuing inpatient monitoring and treatment, and planning for discharge to housing in the following week.

### Differential diagnoses

1. **Borderline personality disorder** – The patient has a history of unstable relationships with family and friends. He endorses a fear of abandonment and a strong desire for interpersonal connection, as evidenced by a prior request for transfer to another room in order to be with a male companion. There are also reports from unit staff of the patient engaging in physical altercations with other patients. Additionally, his psychiatric history is notable for poor impulse control and impulsive, self-damaging behaviors, including suicide attempts and substance use. Collectively, these findings are consistent with a diagnosis of borderline personality disorder.
2. **Major depressive disorder with suicidal ideation** – due to patient's past psychiatric history of major depressive disorder and multiple prior suicide attempts with the most recent inpatient admission for an attempt to jump off a roof or overdose on prescribed Depakote. Additionally, due to psychosocial stressors such as history of physical abuse at his private residence as per patient.
3. **Acute stress disorder** – due to patient's history of physical abuse at home that happen within 1 month, sleep disturbances, and recurrent distressing memory as noted in previous interviews

### Plan

#### Psychiatric

##### Standing:

- Depakote 750mg oral daily, and 1,000 nightly
- Celexa (Citalopram) 30 mg oral daily
- Prazosin (alpha 1 blocker) 1 mg oral nightly

##### As needed:

- Hydroxyzine 25 mg every 6 hours as need for anxiety or insomnia
- Melatonin 3 mg nightly as needed for insomnia
- Zyprexa (olanzapine) 10 mg every 6 hours as needed for agitation.
- Haldol 5 mg IM every 6 hours as need for acute psychosis or severe agitation

##### Borderline personality disorder

- Dialectic behavioral therapy

#### Substance

- Continue substance use counseling

### **Seizures**

- Subtherapeutic levels of valproic acid 21.2 (01/06/2026)
- Previously on Keppra but discontinued due to increased risk of suicidal ideation, as per neurology
- Continue Depakote 1000 mg 2 times daily
  - Reduced dosage to 750 mg due to high level of valproic acid in recent lab (1/28/26)