MARVIX AI

SAMPLE CHILD & ADOLESCENT PSYCHIATRY NOTE

ADHD WITH EMERGING DEPRESSION — AGE 13

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1 PATIENT INFORMATION

NAME
Elijah T. Vasquez-Moore

DATE OF SERVICE
September 17, 2026

DOB
01/22/2013 (13 yrs)

PROVIDER
Sandra Achterberg, MD

AGE / SEX
13 / Male

CREDENTIALS
MD, Child & Adolescent Psychiatry

MRN / PATIENT ID
CAP-337815

VISIT TYPE
Follow-Up / Medication Management — urgent add-on after school suspension

CARE SETTING
Outpatient

REFERRAL SOURCE
Self-referred by mother following school incident

PRIMARY CARE PROVIDER, IF APPLICABLE
Dr. Karen Liu, Pediatrics

THERAPIST / COUNSELOR, IF APPLICABLE
None currently — discontinued 8 months ago

PARENT / GUARDIAN PRESENT
Mother (Denise Moore) present; father joined by phone for final 15 minutes

INFORMANT / COLLATERAL SOURCE
Mother; school counselor report and teacher Vanderbilt scales reviewed

CC CHIEF COMPLAINT

Mother reports: “He got suspended for fighting, he says he hates himself, and he’s stopped eating. I don’t know if it’s the medicine or him.” Elijah states: “I’m just stupid and everyone knows it.”

S SUBJECTIVE

3a REASON FOR PSYCHIATRIC EVALUATION

Urgent follow-up after a three-day school suspension for a physical altercation, in the context of escalating behavioral and mood concerns over four months. Three questions drive this visit: whether new depressive symptoms represent a comorbid mood disorder or demoralization from academic failure; whether stimulant treatment is contributing to appetite suppression and growth slowing; and why academic performance has deteriorated despite adequately treated attention symptoms.

3b MOOD SYMPTOMS

New and clinically significant over roughly four months. Mother reports he is "flat and snappy," no longer initiating activities he previously enjoyed, and has quit the basketball team he loved. Elijah endorses feeling sad "most days," describes himself as "stupid" and "a waste," and reports guilt about disappointing his mother. Anhedonia present — he has stopped drawing, previously a daily activity. Irritability and anger outbursts have increased markedly, with three episodes of yelling and door-slamming in the past two weeks. Tearfulness reported by mother twice, which she describes as very unusual for him. Mood is partially reactive; he brightened when discussing his younger cousin.

3c ANXIETY SYMPTOMS

Significant performance and social anxiety, largely school-focused. Reports stomachaches on school mornings, particularly on days with reading aloud or timed tests. Increasing reluctance to attend school, with three late arrivals in the past two weeks. Avoids raising his hand and reports fear of "looking dumb in front of everyone." No panic attacks, no separation anxiety, no generalized worry outside academic and social domains.

3d ATTENTION / HYPERACTIVITY / IMPULSIVITY

Diagnosed with ADHD combined presentation at age 8. On current medication, teacher Vanderbilt scores show inattention and hyperactivity are meaningfully improved from baseline and are no longer in the clinically significant range for hyperactivity. Residual inattention persists, particularly in reading-heavy classes. Impulsivity remains an issue interpersonally — the suspension incident involved reacting physically to being called a name, without pausing. Disorganization and forgetting homework persist despite medication, which is notable and supports the possibility that a learning disorder rather than attention alone is driving academic failure.

3e BEHAVIORAL SYMPTOMS

Escalating over four months. The index event: he pushed a peer into lockers after the peer mocked his reading aloud in class, resulting in a three-day suspension — his first ever. Two prior verbal confrontations this term. Increased defiance at home, particularly around homework, which mother reports now triggers nightly conflict. No property destruction, elopement, lying, stealing, or cruelty. Notably, the aggression is reactive and consistently provoked by academic humiliation, not predatory or pervasive — an important distinction for diagnosis.

3f TRAUMA-RELATED SYMPTOMS

No history of abuse, neglect, or discrete trauma disclosed by either Elijah or his mother, and none documented. Parents separated when he was 7, which he describes as "sad but okay." No nightmares, flashbacks, intrusive memories, hypervigilance, dissociation, or regression. Trauma screening negative.

3g PSYCHOTIC SYMPTOMS

None. No hallucinations, delusions, paranoia, unusual beliefs, or disorganized thinking. Not responding to internal stimuli. Reality testing fully intact. Self-critical statements are mood-congruent negative cognitions, not delusional in quality.

3h MANIA / HYPOMANIA SYMPTOMS

None. No decreased need for sleep, elevated or expansive mood, grandiosity, pressured speech, racing thoughts, or increased goal-directed activity. Specifically asked given the irritability, which in his case is clearly depressive and reactive rather than episodic elevation. No family history of bipolar disorder.

3i SLEEP AND APPETITE

Appetite is a major concern. Mother reports he eats almost nothing until evening, skipping breakfast entirely and often discarding his lunch. She has found uneaten lunches in his bag repeatedly. Weight has fallen 4 lb over six months during a period when he should be gaining, and this coincides with the dose increase 7 months ago. Evening rebound eating occurs but does not compensate. Sleep: onset delayed to 11:30 pm–12:30 am, taking 60–90 minutes to fall asleep; wakes at 6:30 am for school, yielding approximately 6–6.5 hours — well below the 9–11 recommended at his age. No nightmares. Daytime fatigue reported. No bingeing, purging, or body image concerns.

3j DEVELOPMENTAL HISTORY

Term birth, uncomplicated pregnancy and delivery. Motor milestones on time. **Speech was mildly delayed** — first words around 18 months, with speech therapy in preschool for articulation, discharged at age 5. Social development typical with good reciprocity and no autism concerns. Toilet trained at 3. No regression. Of note, mother now recalls he "never liked books" and struggled to learn letter sounds in kindergarten, which was attributed at the time to being "a boy who wants to move." This retrospective detail is significant.

3k SCHOOL / ACADEMIC FUNCTIONING

Year 8 (13 years old). **Academic performance has declined sharply** — currently failing English and history, passing mathematics with a C, and doing well in art and physical education. This pattern, strong in non-reading subjects and failing in reading-heavy ones, is diagnostically important. Attendance has slipped with three late arrivals in two weeks. Homework rarely completed. Teacher Vanderbilt scales report attention adequate in maths but "shuts down entirely" in English. One disciplinary suspension. Peer relationships were previously good; he has withdrawn from his friend group since being mocked. **No IEP or 504 plan and no psychoeducational testing has ever been performed** — the central gap in his care. School counselor notes he is "bright verbally but cannot get it on paper."

3l HOME / FAMILY FUNCTIONING

Parents separated when he was 7, sharing joint legal custody; he lives with his mother weekdays and his father alternate weekends. The parents communicate civilly but **disagree substantively about medication** — his father believes Elijah is "over-medicated and just needs discipline" and has, on two occasions, not administered the weekend dose. Mother is pro-treatment and carries most of the daily burden; she works two jobs and describes feeling exhausted and guilty. One younger sister, age 8, with whom he is protective and warm. Nightly homework conflict is the dominant household stressor. No household violence, substance use, or housing insecurity.

3m SOCIAL FUNCTIONING

Previously socially successful with a stable friend group through basketball. Since quitting the team and the mocking incident, he has withdrawn, declining invitations and eating lunch alone. Screen use has risen to an estimated 5–6 hours daily, mostly gaming, which mother reports is now his primary social contact. No concerning online behavior, no evidence of cyberbullying on review, no romantic relationships. Reports one remaining close friend.

3n FUNCTIONAL IMPACT

Substantial and cross-domain. School: failing two subjects, suspended, avoiding attendance. Home: nightly conflict, withdrawn from family activities. Peers: socially isolated, quit his sport. Self-care: hygiene has slipped, requiring prompting to shower. Sleep: insufficient. Safety: one aggressive incident. Age-appropriate independence: regressed, requiring more prompting than a year ago.

3o MEDICATION HISTORY AND TREATMENT RESPONSE

Current: lisdexamfetamine 50 mg every morning, increased from 40 mg seven months ago for residual inattention. **Adherence:** generally consistent on school days but inconsistent on weekends given the father's reluctance. **Benefit:** clear and sustained improvement in hyperactivity and classroom attention, corroborated by teacher scales. **Side effects, which are now significant:** marked appetite suppression with a 4 lb weight loss, delayed sleep onset, and a reported "flat" feeling in the afternoons that both mother and Elijah describe. **Prior trials:** methylphenidate at age 8, discontinued after 4 months for irritability and tics that resolved on withdrawal; atomoxetine trialed briefly at age 10 with inadequate benefit. Therapy: attended CBT for 6 sessions two years ago, discontinued when insurance changed; nothing since. No hospitalizations. No neuromodulation.

3p SUBSTANCE USE, IF AGE-APPROPRIATE

First disclosure this visit, offered when interviewed alone without his mother present. Reports vaping nicotine approximately 4–5 times in the past two months, obtained from an older student, most recently one week ago. Describes it as "something to do at lunch now that I sit by myself." No cannabis, alcohol, or other substances. No cravings and no daily use. He asked that this not be shared with his father; confidentiality and its limits were discussed, and he agreed to his mother being informed. This is early-stage and highly modifiable, but is a meaningful marker of social displacement and warrants direct attention.

3q SAFETY CONCERNS

Passive suicidal ideation disclosed during the individual portion of the interview — endorsed thinking "everyone would be better off without me" roughly twice in the past month, most recently after the suspension. Brief, no plan, no intent, no preparatory behavior, and he can identify reasons to live: his mother, his sister, and his cousin. Denies ever having a plan. **No self-harm** — skin inspection with consent showed no marks. No homicidal ideation. The aggression was reactive and provoked, without threats or intent to harm. **Access to means:** mother confirms no firearms in the home; medications currently in an unlocked kitchen cabinet, which was addressed today. No elopement, no risky online behavior, no exploitation, no abuse or neglect concerns, no bullying beyond the single mocking incident.

3r PERTINENT NEGATIVES

Denies active suicidal ideation with plan or intent, self-harm thoughts or behaviors, homicidal ideation, hallucinations, delusions, manic symptoms, cannabis or alcohol use, and abuse or neglect. No acute safety concerns requiring emergency evaluation or hospitalization today. No tics currently. No cardiac symptoms — denies chest pain, palpitations, syncope, or exertional intolerance on stimulant therapy.

ROS CHILD & ADOLESCENT PSYCHIATRIC REVIEW OF SYSTEMS

DEPRESSION / MOOD

Positive — sadness most days, anhedonia, worthlessness, guilt, low motivation, increased irritability

ANXIETY

Positive — performance and social anxiety, somatic stomachaches, emerging school avoidance

ATTENTION / HYPERACTIVITY

Positive for residual inattention and impulsivity; hyperactivity improved on treatment

BEHAVIORAL

Positive — reactive aggression (one suspension), defiance around homework; no property destruction or elopement

TRAUMA

Negative — no trauma history, nightmares, flashbacks, hypervigilance, or dissociation

PSYCHOSIS

Negative — no hallucinations, paranoia, delusions, or disorganized thinking

MANIA / HYPOMANIA

Negative — no reduced sleep need, elevated mood, or grandiosity

SLEEP / APPETITE

Positive — delayed sleep onset (6–6.5 hrs), marked appetite suppression, 4 lb weight loss

OBSESSIONS / COMPULSIONS

Negative — no obsessions, compulsions, or repetitive behaviors

SUBSTANCE USE

Positive — nicotine vaping 4–5 times over 2 months; denies cannabis, alcohol, other substances

SAFETY

Positive for passive suicidal ideation without plan or intent; denies self-harm, HI, or ongoing aggression

O OBJECTIVE / MENTAL STATUS EXAMINATION

5a VITALS, IF OBTAINED

TEMPERATURE
36.6 °C

HEIGHT
158.2 cm (42nd percentile; was 55th at age 12)

BLOOD PRESSURE
112/68 mmHg

WEIGHT
41.8 kg (24th percentile; was 38th six months ago)

HEART RATE
88 bpm, regular

BMI
16.7 (18th percentile)

RESPIRATORY RATE
16 / min

GROWTH PERCENTILES, IF RELEVANT
Height crossed from 55th to 42nd; weight from 38th to 24th — downward crossing on both curves

OXYGEN SATURATION
99% on room air

5b MENTAL STATUS EXAMINATION

GENERAL APPEARANCE
Thin, appropriately dressed adolescent boy appearing his stated age; hygiene mildly unkempt with uncombed hair; slightly underweight appearance; visibly subdued and shoulders slumped on arrival

BEHAVIOR
Initially guarded with mother present, becoming notably more open and forthcoming during the individual portion — a clinically important shift, as both the vaping and the suicidal ideation emerged only then. Cooperative throughout. Eye contact reduced when discussing school. Activity level normal to mildly reduced. Some fidgeting. No agitation, oppositionality, or abnormal movements. No tics observed.

SPEECH / LANGUAGE
Normal rate, reduced volume, fluent and articulate with an age-appropriate vocabulary; comprehension intact. Notably articulate verbally, which contrasts sharply with his written academic performance.

MOOD
Elijah: “Bad. Like I’m failing at everything.” Mother reports “flat and angry” at home over four months

AFFECT
Constricted range, congruent with stated mood, reduced intensity, with preserved reactivity — brightened genuinely when discussing art and his cousin

THOUGHT PROCESS
Linear, logical, goal-directed, and developmentally appropriate. No tangentiality, circumstantiality, disorganization, perseveration, or flight of ideas.

THOUGHT CONTENT
Passive suicidal ideation as described — no plan or intent. Prominent negative self-appraisal (“stupid,” “a waste”) and guilt toward his mother. Worries centered on school and peers. No homicidal ideation, delusions, obsessions, or age-inappropriate content.

PERCEPTION

No hallucinations, illusions, dissociation, depersonalization, or derealization. Reality testing intact.

COGNITION

Alert and oriented. Attention adequate in conversation. Registration and recall intact. Fund of knowledge good and age-appropriate. Executive functioning appears weak on report (organization, task initiation, homework completion). Verbal reasoning notably strong relative to reported academic output — a discrepancy consistent with a specific learning disorder rather than global impairment.

INSIGHT

Partial but developmentally good — he connects his mood to school failure and social isolation, stating "If I could just read like everyone else none of this would happen." This is a genuinely insightful formulation.

JUDGMENT

Fair — impaired in the moment of the altercation, but he expressed regret, articulated alternatives he could have used, and disclosed vaping and suicidal ideation honestly when given privacy

IMPULSE CONTROL

Limited under emotional provocation, as demonstrated by the suspension incident; otherwise adequate

SAFETY

No acute safety concerns requiring emergency evaluation. Passive ideation without plan or intent, identifiable protective factors, engaged caregiver, and means restriction now implemented. Outpatient management with a shortened follow-up interval is appropriate.

DB DEVELOPMENTAL / BEHAVIORAL OBSERVATIONS

PLAY BEHAVIOR AND SYMBOLIC PLAY IF APPLICABLE

Not applicable at age 13; engaged readily around drawing and showed sketches on his phone

PARENT-CHILD INTERACTION

Warm but strained; mother alternated between advocacy and visible frustration; Elijah withdrew when homework was raised and mother appropriately softened when this was named

FRUSTRATION TOLERANCE

Reduced — became visibly tense and terse when reading difficulties were discussed

RESPONSE TO LIMITS AND TRANSITIONS

Appropriate; transitioned cooperatively between joint and individual portions of the interview

SENSORY SENSITIVITIES OR REPETITIVE BEHAVIORS

None observed or reported

SOCIAL COMMUNICATION AND RECIPROCITY

Fully intact — good reciprocity, humor, and perspective-taking; no autism-spectrum features

ATTENTION SPAN AND ACTIVITY LEVEL

Sustained attention through a 60-minute visit with mild fidgeting; consistent with treated ADHD

ABILITY TO FOLLOW DIRECTIONS

Good — followed multi-step instructions without difficulty

SEPARATION FROM CAREGIVER

Separated readily and, importantly, disclosed substantially more when seen alone

EMOTIONAL REGULATION DURING THE VISIT

Maintained composure; became tearful once when describing being mocked, and recovered with support

AS STANDARDIZED SCREENING / ASSESSMENT TOOLS

PHQ-A / PHQ-9

PHQ-A 15 — moderately severe depression (item 9 endorsed as “several days”)

GAD-7 / SCARED

GAD-7 11 — moderate anxiety; SCARED 28, elevated for school and social phobia subscales

C-SSRS

Positive item 2 (passive ideation); items 3–5 negative; no lifetime attempt or preparatory behavior

VANDERBILT ADHD RATING SCALE

Parent: inattention 7/9, hyperactivity 3/9. Teacher (English): inattention 8/9. Teacher (Maths): inattention 3/9 — marked subject-specific variance

CONNERS RATING SCALE

Not repeated this visit; prior 2024 scores showed combined-type elevation

SNAP-IV

Not administered — Vanderbilt used as the primary ADHD instrument

PSC-17

21 — elevated, with the internalizing subscale newly elevated compared with 2024

PCL-5 OR TRAUMA SCREENING TOOLS

Trauma screen negative — no criterion A event identified

MOOD DISORDER QUESTIONNAIRE — ADOLESCENT VERSION

Negative — no evidence of manic or hypomanic episodes

ASRS OR EXECUTIVE FUNCTION SCALES WHEN AGE-APPROPRIATE

BRIEF-2 parent form given today for completion — to assess executive function independent of attention

AUTISM SCREENING TOOLS WHEN RELEVANT

Not indicated — social reciprocity intact, no restricted or repetitive behaviors

SLEEP, BEHAVIOR, OR FUNCTIONAL ASSESSMENT TOOLS

Sleep diary initiated today; two-week log requested

Interpretation and limitations:

The PSC-17 internalizing subscale has newly elevated since 2024, corroborating the emergence of a mood problem rather than a longstanding one. The most informative finding is the Vanderbilt discrepancy: inattention scores of 8/9 in English versus 3/9 in maths from teachers observing the same medicated child. Subject-specific inattention of this magnitude is not explained by ADHD, which is pervasive across settings, and strongly suggests an unidentified reading-based learning disorder. PHQ-A of 15 is likely inflated somewhat by somatic items (sleep, appetite, concentration) that overlap with stimulant side effects, so the true depressive severity may sit slightly lower — though the endorsement of item 9 and the cognitive symptoms of worthlessness and guilt are not attributable to medication.

RA RISK ASSESSMENT

Suicidal ideation, plan, intent, access to means, prior attempts, and protective factors:

Passive ideation approximately twice in the past month, brief and situationally triggered by the suspension and academic failure rather than persistent. No plan, no intent, no preparatory behavior, no rehearsal, and no lifetime attempt. No family history of suicide. Protective factors are specific and credible: his mother, his younger sister toward whom he is protective, his cousin, his art, and a stated wish to “get better at school, not disappear.” He disclosed the ideation voluntarily when given privacy and agreed to tell his mother if it worsened, which is itself protective.

Self-harm thoughts, urges, behaviors, frequency, triggers, and intent:

None. Denies any history of cutting, burning, or other self-injury. Skin inspection performed with his consent and was unremarkable.

Homicidal ideation, threats, aggression, target, means, and protective factors:

No homicidal ideation and no threats. The single aggressive incident was reactive to public humiliation, involved a push without weapon or sustained assault, and was followed by genuine remorse. No pattern of predatory aggression, cruelty to animals, or fire-setting.

Access to medications, firearms, sharps, or other lethal means:

No firearms in the home, confirmed with mother, and none at the father's residence. His stimulant and all household medications were kept in an unlocked kitchen cabinet — **a lockbox was recommended today and mother agreed to implement it before leaving**. Sharps and cleaning products discussed as part of general means-restriction counseling.

Elopement, impulsive risk, unsafe online behavior, exploitation, or high-risk behavior:

No elopement or running away. Impulsive risk limited to the single altercation. Online activity reviewed with mother — gaming with known peers, no evidence of grooming, cyberbullying, or exploitation. Screen time excessive at 5–6 hours but not unsafe in content.

Abuse, neglect, bullying, domestic violence exposure, or mandated reporting concerns:

None identified. No abuse or neglect — both parents are engaged and the home is stable, and the disagreement about medication reflects a genuine difference of belief rather than neglect. The single peer mocking incident does not meet the threshold for sustained bullying, though it will be raised with the school. No mandated reporting obligation triggered.

Psychosis-related safety concerns:

None — no psychotic symptoms and reality testing intact.

Mania-related impulsivity or risk-taking behavior:

None — no manic or hypomanic symptoms currently or historically.

Substance-related risk in adolescents:

Early-stage nicotine vaping, 4–5 lifetime uses over two months, socially driven rather than dependent. No cannabis or alcohol. Risk is currently low but the trajectory matters — vaping initiated precisely when he became socially isolated, so addressing the isolation is the substantive intervention.

OVERALL RISK LEVEL

Moderate

CLINICAL RATIONALE FOR RISK LEVEL

Acute risk is low — passive ideation only, no plan or intent, strong protective factors, engaged caregiver, and means now restricted. Moderate reflects the medium-term concern: a converging picture of new depression, social isolation, academic failure, emerging substance use, and an unaddressed learning disorder, any of which could deepen without intervention. This is a trajectory to interrupt, not an emergency.

Safety plan, caregiver supervision plan, lethal means restriction, crisis resources, emergency instructions, mandated reporting, or higher level of care:

Written safety plan completed collaboratively with Elijah and reviewed with his mother; copies given to both, with agreement to share with his father. Warning signs recorded in Elijah's own words. Coping strategies: drawing, walking the dog, talking to his cousin, music. Adults he will tell: mother, school counselor, and this clinic. Means restriction: medication lockbox to be implemented today; no firearms. Crisis resources provided in writing including the 988 Suicide and Crisis Lifeline and local crisis text line. Emergency instructions: present to the emergency department or call 988 for active ideation, a plan, or intent. Mother instructed on monitoring without interrogating. Higher level of care not indicated; escalation criteria reviewed explicitly with mother.

L LABORATORY AND DIAGNOSTIC RESULTS

Medication Monitoring Labs:

CBC, CMP, and TSH drawn today given weight loss and to exclude a medical contributor to mood and appetite changes — results pending. Prior labs from 2024 were normal. No lithium, valproate, or carbamazepine in use. Pregnancy testing not applicable.

Substance / Toxicology Testing:

Urine drug screen not obtained. Following disclosure of nicotine-only vaping and denial of other substances, testing was discussed with Elijah; given his voluntary honesty, low-risk pattern, and the therapeutic value of preserving that candor, testing was deferred with the explicit agreement that it would be revisited if use escalates or if cannabis or alcohol enter the picture.

Developmental / Psychological Testing:

None ever performed — the principal gap in his care. Comprehensive psychoeducational evaluation formally requested today, specifically to assess for a specific learning disorder in reading (dyslexia) alongside cognitive and achievement testing. The subject-specific Vanderbilt discrepancy, the early letter-sound difficulty his mother recalled, the preschool speech delay, and the strong verbal reasoning with weak written output together make this a high-probability finding. BRIEF-2 issued to parent and teacher for executive function.

Medical / Neurologic Workup:

B12, folate, ferritin, and vitamin D added given restricted intake and 4 lb weight loss — pending; iron deficiency in particular can worsen both attention and mood. No EEG or neuroimaging indicated — no seizure semiology, no focal findings, no atypical features. Sleep study not indicated; the insomnia is clearly stimulant- and mood-related rather than suggestive of a primary sleep disorder.

Cardiac Monitoring:

Blood pressure and heart rate normal on stimulant therapy. No cardiac symptoms and no family history of sudden cardiac death, structural heart disease, or arrhythmia — routine ECG therefore not indicated per guidance. Vitals to be monitored at each visit while on stimulant treatment.

Prior Records Reviewed:

Full clinic record from the 2021 ADHD diagnosis forward, including the methylphenidate and atomoxetine trials and the rationale for each change. Pediatric records from Dr. Liu with complete growth charts plotted from birth — which made the downward percentile crossing on both height and weight clearly visible. School counselor's incident report and suspension documentation. Current-term report card. Teacher Vanderbilt scales from two subject teachers. The 2024 CBT therapy discharge summary. Preschool speech therapy discharge note from age 5. Collateral obtained from the father by phone during the visit.

A ASSESSMENT

A 13-year-old boy with well-established ADHD, combined presentation, adequately treated — now presenting with new moderate depression, reactive aggression, social withdrawal, and early substance experimentation. The unifying formulation is that these are largely downstream of an unrecognized reading-based learning disorder.

The central diagnostic insight is the subject-specific pattern. Teacher Vanderbilt scores show inattention of 8/9 in English but 3/9 in maths, in the same medicated child on the same day. ADHD is pervasive; it does not switch off between periods. That discrepancy, combined with strong verbal reasoning against failing written

output, a preschool speech delay, early letter-sound difficulty his mother recalled today, and failure confined to reading-heavy subjects, points clearly to a specific learning disorder in reading that has never been assessed. He has been medicated for five years for an attention problem that was real but only part of the picture, while the reading disability went unnamed — and, critically, he has concluded from this that he is "stupid."

Major depressive disorder, moderate, single episode — new over approximately four months. PHQ-A 15 with anhedonia, worthlessness, guilt, irritability, sleep disturbance, appetite change, and passive suicidal ideation. This warrants a diagnosis in its own right rather than being dismissed as demoralization, though it is clearly reactive in origin: the timeline maps onto escalating academic failure and social loss. Some somatic items overlap with stimulant effects, but the cognitive symptoms — worthlessness, guilt, and ideation — are not medication artifacts.

Stimulant side effects are now clinically significant and require action. Downward crossing of both growth curves (height 55th to 42nd, weight 38th to 24th), a 4 lb loss during expected pubertal gain, delayed sleep onset yielding 6–6.5 hours, and afternoon flattening. The dose increase seven months ago correlates with onset. The benefit is real and documented, so discontinuation is not indicated — but the risk-benefit balance has shifted and the regimen must change.

Differential considered. Bipolar disorder excluded — irritability is depressive and non-episodic, MDQ-A negative, no reduced sleep need or grandiosity, no family history. Oppositional defiant disorder not supported — defiance is situation-specific to homework and recent in onset, without the pervasive angry-vindictive pattern. Conduct disorder excluded — a single provoked incident with remorse. Autism spectrum disorder excluded — reciprocity, humor, and perspective-taking intact. Substance-induced mood disorder not supported — nicotine use is minimal and postdates the mood change. Medical contributors being screened (thyroid, anemia, vitamin D).

Contributing factors: parental disagreement about medication with inconsistent weekend dosing; no current therapy despite clear indication; social isolation after quitting basketball; 5–6 hours of daily screen use displacing sleep and in-person contact; and significant maternal caregiver strain. **Protective factors:** genuinely good insight for his age, honest disclosure when given privacy, preserved verbal ability and artistic talent, a warm relationship with his sister, an engaged and advocating mother, and a father who — although skeptical about medication — is involved and attended by phone.

P PLAN

Medication plan:

Reduce lisdexamfetamine from 50 mg to 40 mg each morning, returning to the dose he tolerated well before the increase seven months ago. The growth-curve crossing and 4 lb loss during expected pubertal gain make this necessary; the incremental attention benefit of the higher dose is outweighed by growth and sleep cost, particularly since the residual inattention is now better explained by an untreated learning disorder than by underdosing. Do not discontinue — documented benefit is real. Weight and height to be plotted at every visit. **Antidepressant deferred at this visit.** Discussed with mother and Elijah: the depression is significant but recent and reactive, and the more powerful interventions available right now are the learning-disorder assessment, therapy, and school accommodations. If PHQ-A remains at or above 15 in 4–6 weeks despite those, initiate fluoxetine as first-line for adolescent depression, with counseling about the black-box warning and close monitoring. Rationale documented so a future clinician understands why treatment was staged rather than omitted.

Therapy plan:

Individual CBT referral placed — priority. He has been without therapy for two years despite clear indication. Targets: negative self-appraisal ("I'm stupid"), behavioral activation to reverse withdrawal, anger and impulse regulation strategies for provocation, and anxiety management for school avoidance. A therapist experienced with adolescents who have learning differences was specifically requested, since the cognitive distortions are grounded in a real and unaddressed disability. **Family therapy offered** to address the nightly homework conflict and, importantly, to bring both parents into an aligned position on treatment. Mother accepted; father tentatively agreed by phone.

Parent/caregiver guidance:

Reframed the homework conflict directly with mother: nightly battles over reading tasks a child cannot yet do are not a discipline problem and cannot be won that way. Recommended suspending homework enforcement pending the psychoeducational evaluation and school accommodations, which visibly relieved her. Guidance provided on responding to self-critical statements without dismissing them. Sleep routine plan: consistent bedtime, screens out of the bedroom, and a wind-down period. Reinforcement plan focused on effort and specific behaviors rather than grades. Supervision guidance: monitor mood and safety without interrogation, and check in about vaping non-punitively. Mother also encouraged to accept respite support given clear caregiver strain — social work referral offered and accepted.

School plan:

Formal written request for a comprehensive psychoeducational evaluation submitted to the school today, with a copy to mother and the statutory timeline explained to her so she can hold the school to it. Requested interim classroom accommodations pending results: extended time, reduced reading load, text-to-speech and audiobook access, no unprepared reading aloud in class — which was the direct trigger for the altercation — and permission to type rather than handwrite. Recommended an IEP or 504 meeting once testing completes. School counselor to be contacted with consent regarding the peer conflict, the suspension, and a re-entry plan. Attendance plan drafted to address the emerging lateness pattern before it becomes refusal.

Safety plan:

Completed as detailed in the Risk Assessment. Medication lockbox to be implemented today. Crisis resources including 988 provided in writing to both parents. Follow-up interval deliberately shortened to 2 weeks. Escalation criteria reviewed explicitly. Mother instructed to contact the clinic between visits for any worsening, and Elijah given the clinic number directly — which he was told he may use himself.

Substance use plan for adolescents:

Brief motivational interviewing conducted during the individual portion. Explored the function of the vaping — he identified it plainly as "something to do at lunch now that I sit alone," which reframes the intervention around social reconnection rather than prohibition. Provided factual, non-alarmist information about nicotine, adolescent brain development, and dependence risk. He agreed to a goal of no further use and to report honestly at follow-up. Confidentiality limits explained; he consented to his mother being informed and she responded supportively when told. No formal substance treatment indicated at this stage. To be reassessed each visit.

Sleep and lifestyle plan:

Sleep is a specific clinical target given 6–6.5 hours against a 9–11 hour need at his age — insufficient sleep independently worsens mood, attention, and impulse control, so this is not general advice. Dose reduction should assist directly. Consistent bed and wake times including weekends; screens out of the bedroom and off 60 minutes before bed; sleep diary for two weeks. Screen time to be reduced from 5–6 hours with a graduated target rather than an abrupt cut. **Strongly encouraged return to basketball or another physical activity** — it was simultaneously his exercise, his peer group, and his source of competence, and losing it drove much of the isolation. Nutrition: protein-dense breakfast before medication, calorie-dense evening options during the rebound window, and a dietitian referral if weight does not stabilize.

Laboratory or monitoring plan:

CBC, CMP, TSH, B12, folate, ferritin, and vitamin D drawn today — review at follow-up. Height, weight, blood pressure, and heart rate at every visit while on stimulant therapy, with growth plotted rather than merely recorded. Repeat PHQ-A and Vanderbilt scales at 4 weeks. BRIEF-2 forms to be returned by parent and teacher. No ECG indicated. No AIMS — no antipsychotic. Pregnancy testing not applicable.

Care coordination plan:

Pediatrician Dr. Liu updated with consent, particularly regarding growth-curve crossing and the medication change. School counselor contacted with consent regarding evaluation request, accommodations, and re-entry. Therapy referral placed. Social work referral for caregiver support and to help mother navigate the school evaluation process. **Father engaged directly by phone for the final 15 minutes** — this was deliberate and important. His concern about over-medication was validated as reasonable rather than dismissed, and the dose reduction was framed as a shared response to it; he agreed to administer weekend doses consistently on that basis. Aligning the parents was likely the single highest-yield intervention available today.

Patient and caregiver education:

Explained the probable reading disorder to Elijah in direct, age-appropriate terms — that difficulty reading is a specific wiring difference, not a measure of intelligence, and that his strong verbal reasoning is evidence of that. He became visibly emotional and said "So I'm not stupid?" This reframing is likely the most therapeutically significant moment of the visit and should be reinforced at every future contact. Explained the depression as real and treatable, and the plan to address its causes first. Reviewed stimulant side effects, the rationale for reducing rather than stopping, and what to watch for. Warning signs provided in writing to both parents: worsening mood, any talk of self-harm, refusal to attend school, or escalating substance use. Written materials on dyslexia and on parental rights in the school evaluation process supplied to mother.

F FOLLOW-UP

Return in 2 weeks — interval deliberately short given new passive suicidal ideation, the medication change, and the recent suspension. Purposes: reassess mood and safety, evaluate response to the dose reduction including appetite and sleep, review pending labs, confirm the school has acknowledged the evaluation request, and check in on vaping and on the return to activity. Repeat PHQ-A and Vanderbilt at 4 weeks. Therapy intake targeted within 2–3 weeks. Reassess the need for an antidepressant at 4–6 weeks if depressive symptoms have not improved with the environmental and therapeutic interventions. Psychoeducational evaluation results to be reviewed in a dedicated visit once complete, with an IEP/504 meeting to follow. Growth to be plotted at every visit. Mother and Elijah both instructed to contact the clinic sooner, or present to the emergency department or call 988, for active suicidal ideation, a plan, or intent.

TD TIME DOCUMENTATION, IF APPLICABLE

TOTAL TIME SPENT
85 minutes

CARE COORDINATION TIME
15 minutes (school evaluation request, pediatrician, therapy referral)

MEDICATION MANAGEMENT TIME
15 minutes

SAFETY PLANNING TIME
15 minutes

PSYCHOTHERAPY / COUNSELING TIME
20 minutes (supportive and motivational interviewing during individual portion)

RECORDS REVIEW TIME, IF APPLICABLE
20 minutes (growth charts, Vanderbilt scales, school records, prior trials)

PARENT / CAREGIVER COUNSELING TIME
25 minutes (mother, plus 15 minutes with father by phone)

TB BILLING CONSIDERATIONS

E/M LEVEL
99215 — Established patient, high complexity

PSYCHOTHERAPY CODE(S), IF APPLICABLE
90833 — Psychotherapy, 30 minutes, with E/M service (add-on)

FAMILY PSYCHOTHERAPY CODE(S), IF APPLICABLE
Not billed this visit; 90846 anticipated for planned family session

PSYCHIATRIC DIAGNOSTIC EVALUATION CODE, IF APPLICABLE
Not applicable — established patient

BASIS FOR BILLING
Medical Decision Making (high), with add-on psychotherapy; total time 85 minutes documented

PRIMARY CHILD / ADOLESCENT PSYCHIATRIC DIAGNOSIS CODE + DESCRIPTION
F90.2 — ADHD, combined presentation

SECONDARY DIAGNOSIS CODE(S)
F32.1 (major depressive disorder, single episode, moderate); F81.0 (specific reading disorder — provisional, pending testing); R45.851 (suicidal ideation); F17.290 (nicotine dependence, other tobacco product); R62.51 (failure to thrive / growth faltering in child); Z55.9 (academic problem); G47.00 (insomnia, unspecified)

SO SIGNATURE

PROVIDER NAME	CREDENTIALS	SPECIALTY	DATE	TIME
Sandra Achterberg, MD	MD, FAACAP	Child & Adolescent Psychiatry	09/17/2026	16:45

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