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Psychiatric History Taken

1.Patient's personal data

Name:……	Marital status:…..	Occupation:……..
Age:…….	Income:….	Religion:…….
Gender:…..	Education:….	Nationality:……..
Adders:….	Date of admission:….	Source of referral:…..

2. Chief Complain and duration: (Plz**.** *avoid medical terminology).*

This includes the present main problem or sign and symptoms &early duration.

- Document this in the patient's own words.
- Document how long the patient has had the problem; e.g. feeling low for the last few months.
- Use open-ended questions to elicit these e.g. 'Can you tell me about the problems that brought you here?'
- Let the patient speak uninterrupted for the first few minutes before continuing questioning.

3. History of present illness: *(Use simple terms and try to avoid technical scientific terms).*

This include the present problem in chronological way, onset, duration, causation or precipitating factors (life events or change, stressors, conflicts, incompliance to medications) severity of symptoms, and progress (e.g. deterioration of functions) associated with, full analysis symptoms, vegetative symptoms, aggravated factors and reliving factors.

- When did the problem start?
- Has it changed over time? If so how?
- Were there any precipitating events, e.g. bereavement, divorce?
- Any other psychological symptoms, e.g. anxiety, guilt, suicidal ideation?

- Any physical symptoms, e.g. disturbance of sleep or appetite, diurnal mood variation?
- Any psychological/drug treatments for the current problem? If so, did they help?
- Screen for any other problems. All patients should be asked about suicidal ideation, depression, obsession behavior and psychosis.
- Any biological symptoms, e.g. sleep (initial insomnia, middle insomnia, early morning waking), appetite (up or down), diurnal variation in mood, energy, libido, concentration, tearfulness?

4. History of previous illness:

-Past Psychiatric history: Include; any similar or other psychiatric problems in the past?

Previous admission, visit to psychiatrist and faith healer, when the problems occurred, for how long they lasted and what is the treatments (Drugs, ECT and psychotherapy) received. Diagnosis or symptoms and treatment of each number of times, date, duration. Forensic history; include illegal acts, courts and prison.

-Physical and surgical history: Include: illness, operations, accidents and treatment.

5. Family history:
Parents and Siblings:
Include: age, list of jobs, and level of education any psychiatric disorders /other health problems, and, socioeconomic status, relationship with the patient, divorce. If dead time, place and cause of death, the rank of the patient (Make a genogram of the information)
Relatives: Relationships and illness, ask specifically about abnormal personality, mental disorders, substance abuse.

6. Personal life history:
• **Birth and infancy:** Include: pregnancy complications, delivery (normal labor, difficulties and operation) and health status, (premature, low birth weight, convulsions,, asphyxia, hypoglycemia, jaundice and anemia, ect..).
• **Childhood:** family and home atmosphere, developmental milestones; delay in particular steps such as crawling ,standing, walking talking, bowel and bladder control. Behavior problems (Neurotic symptoms; bed wetting, cry, temper tantrum,

hyperactivity, appetite, nail biting, finger sucking, sleep disturbance, fear, mannerism and tics).Social/ family relationships plying (alone, aloof) hostility, avoidant, dependable.

.School & Education: Age to start and finish school, regular or leaving of schooling, (school phobia, truancy or school refusal), succeed or fallen, working during school, relationship among teachers and peers and achievements and ambitions.

.Adolescence and adulthood: Include personality traits social/ family life (isolation and peer group relationships), Behavior problems, difficulties and crises, fantasies and substance abuse.

.Occupational history: Include age of starting to work, list of jobs (current and previous job) and duration, regularity reasons for leaving and any periods of unemployment, relationships, job satisfaction, aspirations and economic status.

.psychosexual history: Feelings, performance, desire, deviant behavior, fantasy, masturbation, worries, guilt, married, if single like to marriage, are they sexually active, any sexual difficulties, first sexual experience /abuse; homosexual or heterosexual (NB: It is not appropriate to elicit disclosure of sexual abuse, but it may be volunteered by the patient), Hair distributions.

For women age of menarche and cycle (regularity, duration, last period), dysmenorrheal, premenstrual tension, menopause (time, symptoms).

.**Marital history:**

Partner; name, age and age of marriage, job, income, personality and health status.

Sex; orgasm, frigidity, and impotence satisfaction &relationship, abortion and contraception, extramarital relationship.

Children; list in chronological order, the name, sex, education, job, health, personality and relationships.

.Habits/dependencies: alcohol, tobacco and illegal drugs; record amount, e.g. units of alcohol per week; current and previous use; patterns of use; symptoms/ signs of dependency and withdrawal; associated problems, e.g. problems at work. Religious practices; Hobbies, interests.

.Forensic history: illegal acts, courts and prison, record all offences whether convicted or not (especially note violent crimes, sexual crimes, sentenced, and persistent offending).

.Present social situation: living standard, income, social environment, who else is at home; social support – friends, relatives, social services.

• **Daily activity;** daily activity life (eating, bathing, dressing, sleeping, ambitions, interest and leisure activities, etc.)

7. Premorbid Personality:

- A useful starting question is 'How would you describe yourself when well?'
- Areas to include: attitudes to others in relationships; attitudes to self, e.g. likes oneself, confident; predominant mood, e.g. cheerful, optimistic; leisure activities and interests; reaction to stress, coping mechanisms.
- Mood: cheerful- despondent, tense-calm, optimistic- pessimistic, stable-unstable, apathetic- inhibited.
- Character: decisive- hesitant, self-confident- shy timed, tolerant- not tolerant, restrained-expressive, trusting- suspicious, irritable -not irritable, sensitive- not sensitive, jealous-not jealous, flexible-in flexible, miser-not miser.
- Moral perfections: self-critic, egocentric, selfish, or altruistic, religious, rigid, or rebellious.
- Energy: energetic, initiative, sluggish, or fluctuant.
- Socially: introvert or extrovert.
- Fantasy life: is he/she a day dreamed.
- Habit and hobbies.

8. Mental state examinations:

General appearance: Dress is it appropriate to weather, sex, tidy, grooming, clean, smell, combed hair and cut nails. Observe the cloths self-care: e.g. bright colors and make-up may be seen in mania, self-neglect in depression,

Facial expression; does he/she looks alert, drowsy, apathetic, happy, anxious, tearfulness, eye contact …etc.

Behavior; Behavior during the interview: restlessness, irritability, appropriateness, distractibility. Setting (relaxed, shift), posture and movement coordination (normal gait, slow, or unstable gait), abnormal movement such as tics, tremor, stereotypes, mannerism, retarded**,** irritable, destructive and aggressive.

Attitude toward examiner; Friendly, cooperative, hostile, defensive, seductive, evasive, withdrawn, frank, stubborn, hostile, bewildered, perplexed or fearful and shame…etc.

Speech:

-Rate (speed): amount, fast, slow, mute, retarded, or pressure to speech, uninterruptible.

-Pitch of sound (Tone): normal, flattened or excessive intonation, soft, angry,

-Volume: whisper, quiet, loud

-Content: excessive punning, clang association, monosyllabic, spontaneous or only in answer to questions. Relevant or irrelevant, coherent or incoherent, circumstantiality, tangentially, perseveration, ward salad, clang association, like animal sound, echolalia, neologism. Dysarthria.

Mood and Affect:

Mood; Observe the patients' mood during the interview and also ask how they are feeling:

(Patient describe for you); Overall emotional state (happy, elated, sad, depressed, irritable fearful, anxious, angry, ambivalent.

Affect: objectively (your impression); current emotional state (appropriate/inappropriate) (full, restricted, flat, inappropriate, suicidal/ homicidal, apathy, euphoric, constricted, bizarre, labile, blunted and unstable, anxious, depressed, elated.

Thought and Thought disorder

1.form of thought; flight of idea, poverty of speech, loosening associations (circumstantial) perseverance, evasiveness (e.g. speech incoherence or irrelevant, verbigeration, neologism, tangentiality, slow or fast thinking, jumping or blocking, distractable) .

2. content of thought; preoccupations /overvalued ideas (these are strongly held and dominate and are not always illogical or culturally inappropriate) obsessions compulsions, ruminations, phobia, rituals, delusions, depersonalization, suicidal attempts, negative views of self, the world and the future.

Delusions: A delusion is a false belief, unshakeable idea.

Types of delusion:

Grandiose – believe they have a special ability or mission.

Poverty – believe they have been rendered penniless.

Guilt – believe they have committed a crime and deserve punishment.

Nihilistic – believe they are worthless or non-existent.

Hypochondriacal delusion – believe they have a physical illness.

Persecutory – (paranoid) believe that people are conspiring against them.

Reference – believe they are being referred to by magazines/television.

Jealousy – believe their partner is being unfaithful despite lack of evidence.

Amorous – believe another person is in love with them.

Perceptions- misperceptions:

1. Illusion; misinterpretation with stimulus.

2. Hallucinations; misinterpretation without stimulus.

(1) Auditory: second-person voices directly addressing the patient (e.g. 'you are useless')

Third-person – two or more voices discussing the patient (e.g. 'he's very powerful')

Ask about timing, triggers, number of voices, first or second person – e.g. the voice may be saying 'I am useless', 'you are useless' or 'he is useless'. Do they recognize the voice?

(2) Visual

(3) Olfactory: usually an unpleasant smell

(4) Gustatory: commonly a feeling that something tastes differently and this is interpreted as being the result of poisoning.

(5) Tactile (Somatic sensations): e.g. sensation of insects under skin or movement of joints.

Cognitive function:

1. Attention and concentration; (e.g. days of week backward).

2. Orientation; (time, place and person)

3. Memory; (immediate, recent, experience and remote)

4. Judgment; (e.g. excessive money or fire exposure).

5. Intelligence functioning: (e.g. mathematics).

6. General knowledge: (e.g. president of Iraq or Kurdistan).
7. Abstract thinking: (e.g. proverb testing)

Insight:

Insight is the degree of awareness and understanding that the patient has regarding his illness.

Ask the patient's attitude toward his present state;

Whether there is an illness or not; if yes, which kind of illness (physical, psychiatric or both); is any treatment needed; is there hope for recovery; what is the cause of illness.

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Reference:

Niraj Ahuja (2011) A Short Textbook of Psychiatry. 7th Edition. Published by Jitendar P Vij. UK.