History taking, psychiatric interview

Dr Maha Suliaman Younis
Assistant professor in Psychiatry
Identifying Data

- Name, Age, Sex, Address, marital status
- Occupation – students? Employment? Unemployed? retired. governmental, regular, for women; housewife
- Education – failure at school, leaving for social reasons
- Religion, race
- Referral source, reason for reference, source
Collateral information (informant)

Next of kin, friend, spouse, others

To validate reliability of the patients history

to add feedback, in cases of drug addiction, personality disorders, mental confusion, dementia or any other cognitive defect

Chief complain (in patients own words)

include duration
History of present illness

Reasons for seeking medical help that day

Current symptoms

Onset, duration, course, stressor, relevant 

Associated symptoms (positive, negative

Past psychiatric history – previous, contact with psychiatrist, sometimes faith healers psychiatric disorders, previous hospitalization in chronological order with dates

Past suicidal attempts, legal history, substance abuse
Family history

- Presence of psychiatric history in the close relatives (even the dead)
- Relationships with his family members
- Past medical history, chronic physical illnesses, medications, neurological disorders
- Caffeine use, smoking
Past personal history

Early Childhood history, prenatal, birth history, post natal illnesses, middle childhood, adulthood

Pre morbid personality, history from patient and close relative usually parents

Schooling, during childhood and adolescence

Psychosexual history, legal history
Mental state examination

Appearance, grooming, posture, gait • physical appearance, body gesture, facial expression (sad, gloomy, anxious, apprehensive, happy, suspicious) • attitude toward examiner (ability to interact, level of eye contact, psychomotor activity (agitation, retardation) • abnormal movement (tardive dyskinesia, tremor, akathesia) • body gesture
Speech

- Rate
- Mute, slow, pressured
- Volume
- Tone
- Fluency
- Articulation
- Quantity
- Spontaneity
Mood and Affect

- **Mood**: subjective emotional state in the patient's own words
- **Affect**: Objective Emotional state in terms of quality
  - euthymic, depressed, elevated, anxious-
  - Range: full, restricted
  - Stability: fixed, labile
  - Intensity: flat, blunted
  - Appropriateness
Thought disorders

- Presence of delusions
- Presence of perceptual disorders (hallucinations)
- Differences between true and pseudo hallucinations
- Any associated medical or neurological symptoms
Cognitive assessment

To evaluate the cognitive state of the patient and exclude any acute defect or dementing process

1. Consciousness
2. Attention
3. Concentration
4. Orientation to time, place, and person
Cognitive assessment

Memory assessment •
Instant memory- •
Short memory •
Intermediate memory- •
Remote memory- •
Intelligence •
general knowledge (cultural factors had to be considered- always •
Mathematical problem (for the illiterates, had to be within- ) the patients field of experience •
Judgment : problem solving ability •
Insight •
Insight

Present (preserved •
Loss •
Partially preserved •
In suspected patients of acute or chronic brain disorders mini mental state examination (scored test) is preferred to be applied
Neurological and physical examination

Is it important •
Careful physical and neurological examination had to be done when history of the patient or his family is suggestive otherwise routine examination and investigations is to follow

Investigations •
As the history suggest further than the routine one
Summery

Formulation of the case is to be done in 5-6 line mentioning the positive and important negative symptoms and sign, family history should be mentioned.

Provisional diagnosis with second and third deferential diagnosis.

Management plan: admission to psychiatric unit, outpatient follow-up, drug administration, oral, i.m, i.v, ECT, non-drug therapy like psychotherapy, occupational, behavioral.