Psychiatric History Checklist

Identifying Data (ID)

- ☐ Name
- ☐ Gender
- ☐ Age
- ☐ Marital status
- ☐ Educational status
- ☐ Occupational status
- ☐ Location where he/she lives and was born

Source of History (SOH) & Reliability

- ☐ If the patient, his/her parents or anyone else is reporting about patient's problem, should be mentioned clearly.
- ☐ Reliability of the taken history should be evaluated during the interview and mentioned after finalizing it.

Report of Relatives (ROR)

- ☐ The reason/complaint that brings the patient in, in patient's companions' words.

Chief Complaint (CC)

- ☐ The main reason/complaint that brought the patient in, in his/her own words. If there are several causes, the one that predominates is considered the main one.

History of Present Illness (HPI)

- ☐ Explaining the CC in medical context and in medical terms.
- ☐ Timing should be considered;
  - Onset
  - Duration
  - Frequency
- ☐ Triggers that caused the problem.
- ☐ Sign and symptoms that occurred along side the CC should be mentioned.
- ☐ The progressing of sign and symptoms should be considered.
- ☐ Patient's function should be evaluated.
- ☐ If there's any treatment history, should just be mentioned and explained in details in the past psychiatric history section.

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Past Psychiatric History (PPH)

- ☐ Explaining the past psychiatric problems in a detailed way, stating any history of hospital admission and outpatient setting treatments.
- ☐ Age of onset and sign and symptoms should be explained in details.
- ☐ The sign and symptoms of the past psychiatric problems should be stated.
- ☐ If there was any history of Electro-convulsive therapy (ECT), should be mentioned.
- ☐ All the patient's reports that are related to anytime – except his/her present illness – should be stated.

SOAP

SOAP consists of four sections, including suicide ideation, organic illness, alcohol/substance abuse, and psychotic features.

- ☐ Suicide Ideation
    - If there's any history of suicide ideation or action, should be explained in details (method, plan, protective factors, social support, hopefulness, and family history).
- ☐ Organic Illness (Past Medical & Past Surgical History)
    - If there's any history of physical illness, should be explained in details.
- ☐ Alcohol/Substance Abuse (Social History & Drug History)
    - Substance itself, method of using it, frequency, sign and symptoms of tolerance and withdrawal, and effect of substance usage on patient's function should be evaluated.
    - If there's any history of using medications, should be mentioned.
- ☐ Psychotic Features
    - If there' any sign of delusions and hallucinations, should be mentioned and evaluated later in MSE sections in details.

Family History (FH)

- ☐ If patient's parents are passed away, should be mentioned.
- ☐ The number of family members and their educational status should be stated.
- ☐ Any history of psychiatric problems in patient's immediate relatives should be mentioned.

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Personal & Developmental History

- ☐ Delivery Hx
  - Patient's overall condition that could be affecting his present problem, should be mentioned.
- ☐ Childhood Hx
  - Patient's growth index, any history of child abuse or neglect, or any history of medical problems that resulted in cognitive impairment, should be mentioned.
- ☐ Educational Hx
  - Patient's educational status, dropping out Hx, educational function, learning problems, and behavioral problems in school should be mentioned.
- ☐ Occupational Hx
  - Patient's occupational status, including variety of jobs, reason of job changing, his/her function during work, and his/her relationship with colleagues, should be mentioned.
- ☐ Marital Hx
  - Marital status, the number of marriages, the number of children, and the overall relationship of patient's family members should be evaluated.
- ☐ Military Service Hx
  - Any history of military service training, war participation, PTSD, etc., should be mentioned.
- ☐ Legal Hx
  - If there's any history of legal problems or prison, should be explained in details.

Mental Status Examination (MSE)

MSE consists of nine sections, including general appearance, psychomotor activity, attitude, speech, emotion, perception, thought, cognition, judgment, and insight (GPA SEPT CJI).

MSE - General Appearance (GA)

- Patient's chronological and apparent age proportionality, and self-care status.
- Patient's eye contact during the interview.
- Patient's overall appearance, and consistency with society cultures.
- If there's any sign of tattoos, surgical scars, or any skin abnormalities – like the ones that could be a sign of past aggressiveness or suicidal ideas – should be mentioned.

MSE - Psychomotor Activity

- Normal (Nomo-active)
- Bradykinesia (Hypo-active)
- Hyperkinesia (Hyper-active)
- Tics
- Stereotypic movements
- Mannerism
- Catatonia

MSE - Attitude

- Co-operative/Uncooperative
- Hostile
- Open
- Guarded
- Seductive
- Eager to please
- Childish
- Suspicious

MSE - Speech

- Patient's smoothness of speech
- Patient's tone (Irritable, anxious, loud, relax, afraid, childish, aphasia)
- Patient's inability to find words
- Dysarthria

MSE - Emotion

Emotion consists of two sections; Mood & Affect.

- Mood could be expressed as below;
  - Euthymic
  - Depressed
  - Anxious
  - Agitated
  - Alexithymic
  - Elevated
  - Euphoric

    - Ecstatic
- Affect should be evaluated in two ways; proportionality and domain.
    - Proportionality; which could be **appropriate** or **inappropriate**.
    - Domain;

        Restricted, Blunted (flat), or labile.

MSE - Perception

- Hallucination
- Illusion
- Depersonalization
- Derealization

MSE - Though Stream, Process & Content

- Thought stream includes;
    - Pressure of speech
    - Poverty of speech
    - Thought blocking
- Thought form or process includes;
    - Flight of ideas
    - Clang association
    - Loosening of association
    - Perseveration
    - Circumstantial thinking
    - Neologism
- Thought content includes;
    - Delusions;
        - Persecutory
        - Reference
        - Grandiosity
        - Control
        - Erotomania
        - Somatic
        - Jealousy
        - Thought broadcasting
        - Thought insertion
        - Thought withdrawal
    - Overvalued ideas

- Obsessions & Compulsions
- Intrusive thoughts
- Suicidal and homicidal ideas
- Phobias

MSE - Cognition

- Patient's alertness
- Orientation
- Memory;
  - Immediate
  - Recent
  - Remote
  - Confabulating
  - Pseudo-memory
  - Deja vu
- Attention and Concentration
- Abstract thinking & reasoning

MSE - Judgment

Patient's ability of evaluating each action's outcome.

MSE - Insight

Patient's awareness of his/her own condition, which is evaluated in five stages;

- Full denial [1/5].
- Little awareness of condition and denying simultaneously due to being afraid [2/5].
- Awareness of the problem but attributing it to external causes [3/5].
- Awareness of the problem but not co-operating in treatment [4/5].
- Full awareness of condition [5/5].

Checklist at a Glance...

- **Identifying Data (ID)**
- **Source of History (SOH) & Reliability**
- **Report of Relatives (ROR)**
- **Chief Complaint (CC)**
- **History of Present Illness (HPI)**
- **Past Psychiatric History (PPH)**
- **SOAP;**
  including suicide ideation, organic illness, alcohol/substance abuse, and psychotic features.
- **Family History (FH)**
- **Personal & Developmental History;**
  including Delivery, Childhood, Educational, Occupational, Marital, Military Service, and Legal History.
- **Mental Status Examination (MSE);**
  including general appearance, psychomotor activity, attitude, speech, emotion, perception, thought, cognition, judgment, and insight.

> 'The practice of medicine is an art, not a trade; a calling, not a business; a calling in which your heart will be exercised equally with your head'
>
> — *Sir William Osler*