History taking in Psychiatry
Heath Care System

Healthy person

Home

Patient

Hospital

Rx
Process of Management
In Psychiatry

Most of the diagnostic information coming from the History and Observation of patients’ appearance and behaviour. Very Important
1. **Personal Data:**
   - Name, age, marital status, occupation, address.

2. **Informant:**
   - Name, relationship to patient and your impression of the informant’s reliability.
3. Reason for referral:
the immediate reason which caused the patient to seek treatment / be brought to hospital
4. Presenting complaints and duration:
The Symptoms (in brief) and their duration
5. History of presenting complaints:

- A description of the symptoms and their duration, including:
- how the symptoms began, and how the symptoms changed with time (e.g. increasing gradually or stepwise / remained the same / episodic in nature)
History taking in Psychiatry  Cont.

5. History of presenting comp.

- Changes in biological functions (e.g. Sleep, appetite, weight)
- Affect of symptoms on patient’s relationships, day to day activity and work
- Association between symptoms and any stressors or life events
- Any other relevant information
History taking in Psychiatry  Cont.

6. Stressors:

Psychological or Physical
7. Family history:
   - age and occupations of parents and the parent’s relationship with one another
   - general information about siblings
   - the patient’s relationship with his parents and siblings
   - social standing of the family
   - history of psychiatric illness, suicide or substance misuse in the family
   - Any other relevant information
8. Personal history:

- Antenatal and birth history
- Early developmental history
- Health in childhood
- Occupational history
- Marital history
- Sexual history
9. Substance use:

- History of substance use: alcohol, nicotine, cannabis, other drugs of use
- Duration of use: amount used at present and frequency of use
- Associated problems (e.g. legal/financial/social problems secondary to substance misuse)
History taking in Psychiatry  Cont.

10. Past medical/surgical history:
History taking in Psychiatry  Cont.

11. Past psychiatric history:

- Does the patient have a past history of psychiatric illness? When?
- Was the illness episodic? Or was the patient continuously unwell?
- Nature of treatment received, and response to treatment? why?
- Drug adherence?
12. Forensic history:
13. Premorbid personality:

- This is an attempt to get an idea about what sort of a person the patient was before he fell ill.
13. Premorbid personality: Cont.

Inquiry about the following features

- Relationships:
- Leisure activities:
- Character:
- Attitudes and standards:
- Prevailing mood:
Mental State Examination
History taking in Psychiatry  Cont.

1. Appearance and behavior:
   - General appearance
   - Posture and movement
   - Attitude towards examiner
2. Speech:

- Rate of speech
- Flow of speech
- Content of Speech
- Volume
3. Mood:

- Anxious
- Depressed
- Elated
- Irritable
- Angry
4. Content of Thought:

- Pre occupations and/or worries?
- Ideas and plans of suicide?
- Ideas and plans of suicide?
- Obsessional ideas/impulses/images and compulsive rituals?
- Delusions/overvalued ideas?
5. Disorders of Perception:

- Hallucinations - auditory, visual, olfactory, gustatory, tactile
- Illusions
History taking in Psychiatry Cont.

6. Cognitive Functions:

- Level of Consciousness
- Orientation in time, place and person
- Attention and concentration
- Memory - short term and long term
- Intelligence
7. Patient understands of illness/Insight:
Thank You..!