**HISTORY TAKING TEMPLATE**

1. **BIODATA**

NAME: …………………………………………………………………………….………..… AGE: …………… SEX: …………..

MARITAL STATUS: …………………………. OCCUPATION: …………………………….. RELIGION: ……….…………….

LANGUAGES: ………………………………………. INFORMANT: ……………………………… RELATIONSHIP: ….……………….

**CHIEF COMPLAINTS** (Pt own words and duration)

1. **ALLEGATIONS** (from others who brought him and duration)
2. **HISTORY OF PRESENTING ILLNESS**

 (What, When and How it developed in chronological order of the symptoms)

(Life circumstances at the time, how illness has affected personality and relationships, activities and psychophysiological symptoms, coping mechanisms and sleep/appetite, important negatives)

1. **RISK HISTORY**

**(**DSH, suicide attempts, self-neglect and by others, thoughts of and actual harm to others)

1. **PAST PSYCHIATRIC AND MEDICAL HISTORY**: (Previous admissions, treatment, facility type, length of stay, effect of treatment, chronic diseases, risk diseases, neurological diseases, substance use, OCPs)
2. **FAMILY HISTORY**

(from patient and relative, traditions, people at home, their relationships, neighborhood, deaths and causes, family tree, family income, each sibling age and occupation, hx of mental disorders)

1. **PERSONAL HISTORY**
2. **Obstetric and Birth** (maternal physical and mental health, unplanned? Substance use? Delivery? Bonding? Weight? Congenital anomalies? Neonatal illness?)
3. **Early Childhood: (**development of motor/ sensory/ social skills, language? Play? Behavior problems? Toilet training? Personality and temperament as a child? School)
4. **Pre puberty to Adolescence: (**peer relationships, school hx, cognitive and motor development, emotional or physical issues, psychosexual history)
5. **Adulthood: (**occupation and career, social activity, sexuality and marital hx, value systems and military hx)
6. **FORENSIC HISTORY** (Arrests, charges and convictions, nature of offences and outcome, including criminal activities where the pt wasn’t arrested)
7. **PREMORBID PERSONALITY**

(generally describe themselves, character, mood, relationships, leisure, spirituality and coping skills)

**GENERAL EXAMINATION AND VITAL SIGNS:**

**SYSTEMIC REVIEW:**

**MENTAL STATE EXAM:**

1. APPEARANCE:

*Personal Identification* (cooperative, attentive, interested, frank, seductive, defensive, hostile, playful, evasive, guarded)

*Behavior and psychomotor activity* (gait, mannerisms, tics, gestures, twitches, stereotypies, touchy, echopraxia, agile, limp, rigid, retarded, hyperactive, agitated, combative or waxy)

*General* (posture, bearing, clothes, grooming, healthy, angry, threatened, features of anxiety, apathetic, perplexed, looks)

1. SPEECH:

(rapid, slow, pressured, hesitant, emotional, monotonous, loud, whispered, slurred, mumbled, stuttering, echolalia)

(intensity, pitch, ease, spontaneity, productivity, manner, reaction time, vocabulary, prosody)

1. MOOD AND AFFECT:

*MOOD:* How does the patient say he/ she feels?

 (depressed, despairing, irritable, anxious, terrified, angry, expansive, euphoric, empty, guilty, awed, futile, self - contemptuous, anhedonic, alexithymic)

*AFFECT*: How the examiner evaluates the patients’ emotions.

(broad, restricted, blunted or flat)

(congruent or incongruent)

1. THINKING AND PERCEPTION:
2. *FORM OF THINKING:*
* **Productivity:** (overabundance of ideas, paucity of ideas, flight of ideas, rapid/hesitant/slow thinking, stream of thought)
* **Continuity of thought:** (goal directed, relevant/irrelevant, loose associations, illogical, tangentiality, circumstantiality, rambling, evasive, perseverance, blocking or distractability.)
* **Language impairments**: word salad, clang associations, neologisms.
1. *CONTENT OF THINKING:* (Preoccupations, obsessions, compulsions, phobias, suicidal/homicidal ideations, hypochondriacal symptoms)
2. *THOUGHT DISTURBANCES:* (Delusions, ideas of reference/ influence, thought broadcasting, thought insertion)
3. *PERCEPTUAL DISTURBANCES:* (Hallucinations, illusions, pseudohallucinations, depersonalization and derealization)
4. *DREAMS AND FANTASIES: (*recurrent, prominent, favourite and nightmares)
5. SENSORIUM:
6. *ALERTNESS*: (environment awareness, attention span, clouding of consciousness, GCS,
7. *ORIENTATION: (time, place and person)*
8. *CONCENTRATION AND CALCULATION:* (addition, subtraction, multiplication and division)
9. *MEMORY: (*recall, recent, remote, episodic)
10. *FUND OF KNOWLEDGE/ INTELLECT:* (age appropriate intelligence and general knowledge)
11. *ABSTRACT THINKING:* (concept formations, similarities, differences, absurdities, simple proverbs, appropriateness of answers)
12. *JUDGEMENT:* (social judgement and test judgement)
13. *INSIGHT*: (Denial, slight awareness, awareness, intellectual insight, true emotional insight)

**DIAGNOSTIC FORMULATION**

**DIAGNOSIS:**

**DIFFERENTIAL DIAGNOSIS**

**PLAN OF MANAGEMENT:**