**Psychiatric assessment outline**

**History**

***Bio data/ basic information***

Name, age, marital status, current occupation, current residence, route of referral, admission status under the mental health act (voluntary, involuntary, emergency), source of information

***Presenting complaints***

Number and brief description of the presenting complaints or allegations

**History of presenting complaints**

For each individual complaint, record its nature (in the patient’s own words as much as possible). Chronology, severity, associated symptoms. Any relieving or aggravating factors. To what does the patient attribute the symptoms to?

***Medical history***

Current medical conditions and their treatments, chronological list of episodes of medical or surgical illness; any drug allergies

***Past psychiatric history***

Previous psychiatric diagnosis, chronological list of episodes of psychiatric in patient treatment; outpatient care; any non-prescribed or traditional/ alternative treatments sought

***Family history***

Can do a family tree

Detail names, ages and relationships of especially first degree relatives. Are there any familial illnesses? Any history of suicide (completed or attempts) in the family- even extended family

***Personal history***

*Childhood*

Problems during pregnancy or delivery; were developmental milestones appropriately reached? In what sort of family were they raised?

*Education*

Primary and secondary schools attended; if more than one, what was the reason, was it main stream or special school; did they enjoy school, if not, why not; age left school and qualification; type of further education and qualifications attained; if dropped out at any stage, why?

*Employment*

Chronological list of jobs and reasons for leaving the employment; account for periods of unemployment in the history. Is the undertaken job consistent with education level?

*Psychosexual history*

Sexual development: menarche, sexual debut….

*Relationships & marriage*

Sexual orientation; chronological account of major relationships; reasons for relationship breakdown; are they currently in a relationship? Children from current or previous relationship? Who do the children live with? What relationship do they have with the patient?

*Forensic*

Have they been charged or convicted of any offences? Sentence received?

*Substance use*

Alcohol and illicit drug use: duration, amount; negative consequences of substance use e.g. tolerance, withdrawal, effect on present illness

*Current social circumstances*

Housing situation, finances, stressors, social support

*Premorbid personality*

How would they describe themselves before they became ill? How would others have described them?

***Review of systems***

Any other complaints that may or may not be related to the mental health symptoms in the various systems: CNS, CVS, GIT, genital-urinary

Not forgetting to ask about the following if they never came up in presenting complaints: sleep, appetite, anxiety symptoms

**Mental status examination (one point in time)**

***Appearance and behaviour***

Appearance

Apparent age, race, level of cleanliness, general physical condition, abnormal involuntary movements such as tics, grimace, stereotypies, tremors

Behaviour

Appropriateness of behaviour, level of motor activity, eye contact, abnormal movements or postures, distractibility, episodes of aggression, rapport, attitude….

***Speech***

Volume (loud, low), rate (rapid, slow) and tone (monotone, slurred); speech impairment (dysarthria, stuttering, echolalia

***Mood and affect***

Mood is the emotional state the patient experiences internally

Affect is the outward emotional expression of the patient’s internal emotional state

Mood in relation to affect

***Perception***

Hallucinations (false perceptions of a sensory stimuli and involve any sensory modality)

depersonalization, derealisation, illusions

***Thought form (process)***

Loosening of associations, tangential thinking, circumstantiality, blocking, perseveration, flight of ideas

***Thought content***

Delusions, overvalued ideas, preoccupations, obsessive thoughts, ideas and impulses, thoughts of suicide and deliberate self-harm, thoughts of harm to others (assess intent, lethality of intent and plan)

***Judgement***

Check whether the patient can understand the consequences of his actions…

***Cognition***

Attention and concentration; orientation to time, place and person; level of comprehension; short term memory;

***Insight***

Does the patient feel his experiences are as a result of the illness? Will he accept medical advice and treatment?

**Physical examination**

Vital signs

Guided by history, MSE and review of systems.

**Case Summary**

* Brief synopsis of the case: short paragraph summarizing Bio data; description of presentation; previous psychiatry diagnosis; important positives in the history (family history of mental health problems, substance use, positive forensic history etc.); positive features and important negatives like suicidality, insight in MSE; significant physical examination findings.
* Diagnosis and differential diagnosis (In psychiatry we also note the presence of comorbidities i.e. one could have more than one diagnosis)
* Formulation: why has the person become ill, and why now. Identify predisposing, precipitating and perpetuating factors. Formulation guides the management plan.
* Management plan
	+ Necessary investigations
	+ Treatments: Biological; psychological and social
* Prognosis