Psychiatric History Taking

See online here

In psychiatry, one needs to be systematic with the approach to the patient so that no less obvious information that might be crucial to the diagnosis is missed. History taking is one of the main tools used by the psychiatrist during their interview with the patient suspected to have a mental disorder.

Introduction to Psychiatric History Taking

Psychiatric history involves the subject’s mental profile that comprises information about the chief complaint, present illness, family and individual history, psychological deviation from the onset of the disease and history of early development. A psychiatrist usually focuses on other nonverbal clues during their session with the patient and not the mere history provided by the patient. The patient’s eye contact, avoidance of eye contact when certain subjects are brought for discussion, and the patient’s look and clothing all have some significance in the psychiatrist’s evaluation of the patient.

For the psychiatrist to be able to obtain a reliable and complete history, he or she should build a good rapport with the patient. In contrast to other medical disciplines, psychiatry is unique in that many personal conflicts are sometimes needed to be addressed and discussed for a diagnosis to be made. Rapport is not only about trust, but it is also about respect and boundaries. Many psychiatric patients tend to misunderstand the nature of the relationship between them and their therapist. Direct
eye contact, detailed explanation of what is going on, and addressing all the patient’s concerns can solve this issue.

**Different types of histories:**

- Presenting complaint
- History of present illness
- Past psychiatric history
- Social and developmental history
- Past medical/surgical history
- Medications/allergies
- Family history

**Question types**

The patient must be observed when he enters the clinic. His personal grooming like dress up during a season. During history taking, it is recommended to start with open-ended questions and let the patients express their own ideas, opinions, and concerns. **Once the main problem or problems have been identified, close-ended questions should be asked.**

For instance, a patient who is saying that he or she is depressed, sad all the time, and feels worthless or guilt should be specifically asked whether he or she has thought of suicide. This direct question might be intruding and leading, but in fact, research has shown that most patients appreciate such a question and concern from their therapists.

**History Components of Psychiatric History Taking**

The components of medical history in the psychiatric ward are like what is obtained by other medical doctors in other with few minor differences. Social, personal, and psychiatric family history are usually more detailed when taken by a psychiatrist.

**Personal History**

Ask them about their name. In a psychiatric setting, one should also ask if the patient has any other names he prefers to use or if he uses multiple names. A young patient or a child should be also asked about his or her current school grade. Such an introductory question can loosen the boundaries between the doctor and the patient. The patient’s chief complaint should be noted in quotation marks in the patient’s record.

**Note:** Questioning about the marital status, occupation and current living circumstances is also beneficial to the psychiatrist. Religious beliefs should be addressed at this stage but without going into detail.

If the patient is diagnosed with a delusional disorder, it should be noted that the delusion should not be accepted culturally or religiously. Therefore, the documentation of the patient’s sex and race is also needed.

**Chief Complaint**

This is very important as it guides the next part of the history, “history of present illness”. The chief complaint of the patient should be documented in the patient’s own words. An open-ended question is recommended here. Mental state before the appearance of chief complaint should be noted.
History of Present Illness

The history of the present illness is a detailed exploration of the patient’s main complaint or concerns. This is the most important part of history as the diagnosis and treatment plan is highly dependent on the information provided in this section. Like history taking in other medical disciplines, one should inquire about the onset of symptoms, any associated symptoms, what aggravate or alleviate the symptoms, whether the symptoms were acute or chronic and how the symptoms affected the patient.

In psychiatric patients, the history of the present illness is sometimes provided by the family as well or those close to the patient. When this is the case, it should be noted whether the patient acknowledges these symptoms or not and whether he or she has insight.

Past Medical History

Past medical history is very important in psychiatric patients. All previous medical conditions or current and chronic medical diseases should be documented here. When you go through the DSM-V criteria for the different mental disorders, you will notice that a universal criterion has been put in almost all the diagnostic criteria for the different mental disorders, i.e. for the symptoms to not be caused by a medical condition or substance use.

Past medical history in addition to full laboratory and imaging diagnostic workup are the main tools to exclude medical conditions as the cause of psychiatric symptoms in the patient. Any surgical history should be questioned to review complete medical history.

Medication and Allergies

The current patient’s medications should be listed in detail. The used dosage, route, and indication should be noted too. The patient’s compliance should be noted as it can have some clues towards the probable diagnosis. Drug-seeking behaviors for instance in opiate addicts should also be noted.

Specific questioning about previous food or drug allergies should be done. Many antipsychotic medications or mood stabilizers can cause allergic reactions.

Past Psychiatric History

The previous history of psychiatric disorders should be documented as it puts the patient at an increased risk of developing a relapse or another psychiatric condition. Details such as past psychiatric illness and therapy involved with doses, compliance and specific benefit of the medications should be noted, for instance, anxiety disorders patients are at an increased risk of developing a major depressive disorder.

Family History

Family history of medical or psychiatric conditions should be documented. A family history of major depressive disorder or anxiety disorders and any history of successful treatment with a specific drug regimen is known to put the patient at an increased risk of developing mood or anxiety disorders. Paternal post-traumatic stress disorder has been
associated with increased cortisol levels in the offspring, increased frequency of panic attacks and increased risk of other anxiety disorders in the children.

**Ask about family history:**
- Psychiatric illness
- Suicide attempts
- Violence
- Members having treatment

**Social History**

Social history is very important to the psychiatrist. For any psychiatric disorder to be considered as significant, the patient’s social and occupational life need to be affected. Employment history, current problems at work, educational history, financial condition and previous problems at school should be inquired about.

Inquiry about the patient’s partner or partners should be also attempted. Documentation of the patient’s children’s age, sex, and education level should be performed. Tobacco use, drug abuse, and alcohol use or abuse should be inquired about and documented in your history. In DSM-5 diagnostic criteria for mental disorders, the symptoms appearing due to substance abuse or alcohol should be excluded.

In psychiatric patients, it is **essential to inquire about the current housing conditions**. If the patient is going to be discharged to go back to the streets, the chances of relapse are very high. Inquire about the patient’s family including siblings and parents and check if the patient has a good support circle that he or she can lean on when needed.

You should also inquire about the patient’s hobbies, social activities and whether he or she has friends. Type of involvement in the society and social activities determine the history of the previous mental, physical or verbal abuse should be documented.

At this stage, it **might be appropriate to go into detail about the patient’s own belief system**. Questioning the patient’s bringing up is beneficial. Asking the patient’s religious beliefs about psychiatric disorders or suicide should be documented.

**Developmental History**

Perinatal history and developmental history should be obtained. Pervasive developmental disorders including autism, autistic spectrum disorders, and Asperger’s syndrome are dependent on developmental history.

**Assets**

This is another specific history component to psychiatric history. The patient’s strengths should be noted as they can be used later in your management plan. The patient’s verbal skills, whether he has above average intelligence, or agreement to get treatment are some common assets that should be documented in your history.

**Note:** The willingness of the family to participate in family treatment or group therapy should be also noted as an asset.

**Mental state examination**

Mental state examination or MSE is performed to record patient’s race, sex, age, nutritional status and behavior in the interview like eye contact and mental states like
delirium or delusion or nervousness.

References

History and Mental Status Examination via emedicine.medscape.com

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