BIODATA
PRESENTING COMPLAINTS
HISTORY OF PRESENTING COMPLAINTS
PAST PSYCHIATRIC HISTORY
HISTORY OF SUBSTANCE ABUSE
PAST MEDICAL HISTORY
DEVELOPMENTAL HISTORY
SOCIAL HISTORY
FAMILY HISTORY
EMERGENCY CONTACT INFORMATION

BIODATA
Name
Age
Sex
Occupation
Religion
Marìtal Status
Address
Tribe

Source of information: patient or a family member/friend

<u>Presenting Complaint(s)</u>
Use open questioning to explore the patient's presenting complaint:

"What's brought you in to see me today?"
"Tell me about the issues you've been experiencing."
Provide the patient with enough time to answer and avoid interrupting them.

Facilitate the patient to expand on their presenting complaint if required:

"Ok, can you tell me more about that?"
Once the patient has finished speaking, it is helpful to check if there are any other issues. If the patient has multiple presenting complaints, work with them to establish a shared agenda for the rest of the consultation.

Depending on the setting (inpatient vs. outpatient) and the patient's current mental state, some information may need to be gathered from a collateral history. A collateral history is particularly important if a patient has been detained under the Mental Health Act, as it will help to provide information about the patient's background and what prompted the assessment and admission.

Open vs. Closed Questions

History taking typically involves a combination of open and closed questions. Open questions are effective at the start of consultations, allowing the patient to tell you what has happened in their own words. Closed questions can allow you to explore the symptoms mentioned by the patient in more detail to gain a better understanding of their presentation. Closed questions can also be used to identify relevant risk factors and narrow the differential diagnosis

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History of Presenting Complaint

You should then explore the presenting complaint in more detail. Patients can present with a wide range of symptoms, ranging from mania, low mood, hallucinations, anxiety, delusions, and memory loss.

Key psychiatric symptoms/presentations

Low mood (depression)
Self-harm/suicidal ideation
Elevated mood and energy (hypomania and mania)
Anxiety, panic attacks, or phobias (anxiety disorders)
Delusions and hallucinations (psychosis)
Obsessions or compulsions
Alcohol or substance abuse
Issues around food or weight (eating disorders)

When exploring symptoms, you can use the acronym NOTEPAD:

Nature
Onset
Triggers
Exacerbating/relieving factors
Progression
Associated symptoms
Disability

DEPRESSION

When taking a history from a patient presenting with low mood, it is important to explore the core symptoms of depression and the associated biological and somatic symptoms.

The three core symptoms of depression are low mood, lack of pleasure (anhedonia), and low energy levels.

“How has your mood been recently?”
“Have you felt low in yourself?”
“Have you felt little interest or pleasure in doing things?”
“Have your energy levels been lower than normal?”
“Have you been feeling more tired than normal?”
Associated symptoms to ask about in depression include:

Disturbed sleep (this may be increased or decreased)
Change in appetite and/or weight (this may be increased or decreased)
Agitation or slowing down of movements and thoughts
Poor concentration
Lack of hope for the future
Feelings of worthlessness
Feelings of excessive or inappropriate guilt
Reduced libido
Thoughts of self-harm
Thoughts of death or suicide

When exploring negative thoughts in depression, it can be helpful to start with self-esteem, confidence, guilt, worthlessness, hopelessness and suicidal thoughts. This structure makes it easier to explore sensitive themes. It also allows you to use the normalisation technique before asking about suicidal thoughts:

“It is not uncommon that people who have been feeling and thinking in this way start thinking about suicide. Have you had any similar thoughts?”

It is also important to remember that patients with depression may not present with low mood but can present with non-specific symptoms. This is particularly true in older patients, who may only present with physical symptoms or an apparent cognitive decline.

Hypomania/Mania

Episodes of mania and hypomania are part of the diagnostic criteria for bipolar disorder, and patients will present with an elevated mood and increased activity and energy.

Several characteristic symptoms are common to both hypomania and mania, but the time frame, specific symptoms and the impact on function will help you to differentiate between the two.

“Have you noticed any change in your mood or energy levels recently?”
“Can you describe the change?”
“Have you felt more irritable or impatient than usual?”

“Are you having any problems in your job/relationships?”
“How are you sleeping at the moment? Is it more or less than normal?”
“How is your appetite?”
“What is on your mind at the moment?”
“Can you do things that other people might find difficult or impossible?”
Other symptoms associated with mania/hypomania may include:

Increased self-esteem
Reduced social inhibitions
Over-familiarity
Reduced attention
Spending recklessly
Inappropriate sexual encounters
Preoccupation with extravagant or impractical plans
Persecutory delusions
Incomprehensible speech
Self-neglect
Loss of insight
Depending on the severity of symptoms, it can be very challenging to take a history from a patient experiencing a manic episode.

They may not be able to concentrate enough on the assessment to give complete answers. However, if this is the case, then a significant amount of information can still be gathered from your mental state examination. In this situation, returning later to complete the history may be appropriate.

A collateral history is also extremely useful when assessing a patient with mania/hypomania as they will often be able to give a much clearer description of the changes in behaviour and impact on functioning.

Anxiety Disorders
Anxiety is an unpleasant physical and psychological set of symptoms that occur in response to a potential/uncertain threat. Its basis as a survival mechanism means it can be very disabling and difficult to manage.

There are several anxiety disorders, including generalised anxiety disorder, specific phobias, and panic disorder. There are many psychological and physical symptoms associated with them all that you should ask about.

“Have you been worrying a lot about things recently?”
“What sort of things have you been worrying about?”
“Do you feel wound up or tense?”
“Are you always anxious or does it happen at certain times?”
“Do you get sudden ‘attacks’ of anxiety?”

“Are you able to put your worries out of your mind?”
“Do you avoid doing things because of your worries?”
“Have you ever felt detached from yourself or your surroundings?”
Physical symptoms that may be associated with anxiety disorders include:

Palpitations
Chest tightness
Breathlessness
Sweating
Dizziness
Dry mouth
Nausea and vomiting
Insomnia/difficulty sleeping
Paraesthesia
It is important to screen for co-existing depression in patients presenting with anxiety.

PSYCHOSIS

Psychosis occurs when a patient has lost touch with reality, so assessing them can be challenging and daunting. It is useful to have some standard screening questions for common symptoms found in psychotic disorders.

“I have to ask you some questions that may seem a little bizarre and may not make sense. These are questions we ask of everyone. Would that be ok?”

Symptoms of psychosis generally include hallucinations, thought abnormalities, and delusions. These symptoms are included within the first-rank symptoms of schizophrenia, but they can be found in other disorders.

HALLUCINATIONS

Hallucinations can take the form of any sensory modality, and different modalities are more strongly associated with different disorders. For example, schizophrenia is generally associated with auditory hallucinations, whereas Lewy-body dementia is more associated with visual hallucinations.

“Do you ever hear noises or voices when there is nobody else there?”
“Do you ever feel that someone or something is touching you when there is nobody there?”
“Have you ever felt like you’ve been assaulted despite nobody being present?”
“Have you ever felt like insects are crawling beneath your skin?”

DELUSIONS

Delusions are fixed beliefs that are out of keeping with regional/cultural norms. These beliefs are still held, even in the face of contradictory evidence.

Whilst it may be necessary to gently challenge a delusional belief to establish if it is fixed in nature, it should be done carefully so as not to cause too much distress to the patient, which may result in a breakdown of rapport.

A common delusion is a persecutory delusion, in which the patient believes another individual or group is trying to harm them.

“Do you sometimes have thoughts that others tell you are false?”
“Do you have any beliefs that aren’t shared by others you know?”
Disorders of thought content can also be considered as delusions. These include thought withdrawal (the belief that thoughts can be removed from their mind), thought insertion (the belief that thoughts can be inserted into their mind), and thought broadcasting (the belief that others can hear their thoughts). Formal thought disorder, such as thought blocking (sudden cessation of thought), should be covered in the MSE.

“Is there anyone or anything taking thoughts out of your head?”
“Are your thoughts your own?”
“Is there anyone/anything putting thoughts into your head that you know are not your own?”
“Can anyone hear your thoughts? For example, can I hear what you are thinking right now?”
“Do you ever hear your own thoughts echoed or repeated?”

OBSESSIONS AND COMPULSIONS

Obsessions are thoughts, images, or impulses that are recurrent and intrusive. They enter the mind despite resistance and are recognised by the patient as their own thoughts (i.e. not as a result of thought insertion). They are generally extremely distressing for the patient, and they tend to remain aware that these thoughts are irrational but still feel they have no control over them.

Compulsions are repetitive mental processes or physical acts a patient feels compelled to perform due to an obsession or rule. They are carried out in an attempt to reduce the distress and anxiety associated with the obsessions – even though they are not linked to the specific thought or are excessive (e.g. the stereotyped compulsion of repeated handwashing in response to an obsessive fear of bacteria or dirt).

These two symptoms are characteristic of obsessive-compulsive disorder (OCD) but can also occur in other illnesses, such as depression, personality disorders, and health anxiety disorder.

“Do you get repeated unpleasant thoughts or images coming into your mind?”
“Do you get these thoughts entering your mind despite trying to keep them out?”
“Do you ever feel that you need to repeatedly check things you have already done?”
“Do you ever feel that you need to arrange, touch, or count things repeatedly?”
“Do you try to resist the thoughts or the urge to respond to them

ALCOHOL AND SUBSTANCE ABUSE

The use of alcohol and/or recreational drugs is common, and they may represent a trigger for another psychiatric condition, an attempt to manage the symptoms of an undiagnosed psychiatric condition, or a substance misuse disorder in their own right.

There are several screening questions for alcohol use, for example, “CAGE“:

“Have you ever felt you ought to Cut down on your drinking?”
“Have people Annoyed you by criticising your drinking?”
“Have you ever felt Guilty about drinking?”
“Have you ever felt you needed a drink first thing in the morning (Eye-opener) to steady your nerves or get rid of a hangover?”
If the answer to two of these questions is yes, it is worth taking a full alcohol history.

Questionnaires such as AUDIT-C can help to quantify the amount of alcohol consumed, but generally, it is important to establish what is drunk and when, the presence of physical withdrawal symptoms, tolerance, whether they have had adverse effects from drinking, if they have continued to drink despite this and if they have tried to cut down the amount they drink before

The same types of questions should be asked regarding the use of recreational drugs. However, it is important to remember that non-illicit drugs, such as opioid analgesics, can be misused.

For recreational drugs, the amount of money spent tends to be a good guide to intake, and it is important to consider the route of administration – if needles are used, are they shared? And has the patient been tested for blood-borne viruses?

There are a few potential questions that you can ask to screen for dependence on any substance:

“Do you feel a strong desire or compulsion to take ___?”
“Do you often take more than intended?”
“Have you ever experienced withdrawal symptoms?”
“Do you find that you need to take more of ____ to achieve the same effect?”
“Has your use of ____ made you give up important obligations?”
“Has the use caused any physical or mental health problems?”
“Have you continued to use, even though you knew you had problems?”

EATING DISORDERS

In an eating disorder, the patient uses the control of food to cope with feelings and/or other situations. They generally involve eating too little or too much, purging behaviours, or worrying excessively about body weight or shape.

The most common eating disorders are anorexia nervosa, bulimia nervosa, and binge eating disorder. Patients may self-present with concerns about an eating disorder or present as a result of concerns from family and friends.

“Can you describe a typical day’s food intake?”
“Are you on a diet at the moment?”
“What has your weight been like in the past?”
“How often do you weigh yourself?”
“How do you feel about your body?”
“What do other people say about your body?”
These questions will build a picture of the patient’s weight history, beliefs around eating and eating behaviours.

After this, it is important to ask about any adaptive behaviours. These adaptive behaviours can include exercise (what sort of exercise, and how much?), purging behaviours (vomiting, medication use, and insulin abuse if diabetic), and binge eating (what do they eat in a binge, are there any triggers and how do they feel after?).

Physical signs and symptoms are extremely important to explore in eating disorders, as these disorders can cause significant disturbances to normal homeostatic function, and patients may require admission to the hospital to manage these:

Amenorrhoea
Fatigue
Constipation
Dizziness
Haematemesis (due to oesophageal tears)
Seizures

IDEAS, CONCERNS AND EXPECTATIONS

A key component of history taking involves exploring a patient’s ideas, concerns and expectations (often referred to as ICE) to gain insight into how a patient currently perceives their situation, what they are worried about and what they expect from the consultation.

The exploration of ideas, concerns and expectations should be fluid throughout the consultation in response to patient cues. This will help ensure your consultation is more natural, patient-centred and not overly formulaic.

It can be challenging to use the ICE structure in a way that sounds natural in your consultation, but we have provided several examples for each of the three areas below.

Ideas

Explore the patient’s ideas about the current issue:

“What do you think the problem is?”
“What are your thoughts about what is happening?”
“It’s clear that you’ve given this a lot of thought and it would be helpful to hear what you think might be going on.”

Concerns
Explore the patient’s current concerns:

“Is there anything, in particular, that’s worrying you?”
“What’s your number one concern regarding this problem at the moment?”
“What’s the worst thing you were thinking it might be?”

Expectations
Ask what the patient hopes to gain from the consultation:

“What were you hoping I’d be able to do for you today?”
“What would ideally need to happen for you to feel today’s consultation was a success?”
“What do you think might be the best plan of action?”

SUMMARY
Summarise what the patient has told you about their presenting complaint. This allows you to check your understanding of the patient’s history and provides an opportunity for the patient to correct any inaccurate information.

Once you have summarised, ask the patient if there’s anything else that you’ve overlooked. Continue to periodically summarise as you move through the rest of the history.

PAST PSYCHIATRIC HISTORY
After exploring the patient’s presenting complaint, you should explore other areas of the history. A past psychiatric history is extremely important, as it may help with reaching a diagnosis.

Ask the patient about their past psychiatric history:

“Have you ever experienced symptoms like this before?”
“Have you ever had any problems with your mental health before?”
“Have you ever been diagnosed with a mental health problem?”
“Have you ever had any treatment for your mental health before?”
“Have you ever had any contact with mental health services before?”
“Have you ever been admitted to hospital due to your mental health before?”
Any relevant past psychiatric history from these questions should then be explored in more detail.

EXISTING PSYCHIATRIC DIAGNOSIS

If a patient has an existing psychiatric diagnosis, it is important to find out when it was diagnosed and any significant details. The current presentation could be a relapse of an existing condition, or it may lead to a change in diagnosis. For example, a patient presenting with low mood may receive a diagnosis of bipolar disorder if they have previously experienced mania/hypomania

Previous Treatments

You should explore any previous treatments the patient may have received, particularly in those with complex histories.

The effectiveness of previous treatments should also be clarified, as it may change the medication given depending on their experiences. If they have been treated for mental health problems before, it is also worth asking if they have received electroconvulsive therapy (ECT) in the past – as this may signify that they are relatively resistant to treatment

PAST CONTACT WITH MENTAL HEALTH SERVICES

For previous contact with mental health services, you should explore whether this has been through primary care, the community mental health team, or the crisis team/home treatment team.

Some areas may also have specific community teams, such as an early intervention in psychosis service. You should also determine if the patient is under the care of a mental health team and who they see. For example, if they have a community psychiatric nurse or care coordinator, these professionals should be able to provide more background information.

If they have previously been admitted to the hospital due to their mental health, then you should clarify:

The number of admissions

The dates (if known, otherwise the rough length of stay)

If they were informal admissions or under a section of the mental health act

If they have ever been admitted to a psychiatric intensive care unit (PICU).

PAST MEDICAL HISTORY

Ask if the patient has any medical conditions:

“Do you have any medical conditions?”

“Are you currently seeing a doctor or specialist regularly?”

“Have you ever had any operations?”

The past medical history will generally be the same as in any patient history. There can be significant overlap between mental and physical health, and it is always important to exclude physical causes for the patient’s symptoms. For example, hypothyroidism may present as low mood, or encephalitis can present as psychosis.

Some medical conditions are also risk factors for mental health disorders, such as chronic illness (e.g. chronic pain or cancer), a major risk factor for depression.

Additionally, some medical conditions will affect treatment options. For example, cardiovascular, renal, or hepatic disorders are often contraindications for psychiatric medication.

A new psychiatric diagnosis may also mean a patient’s physical health needs to be managed

differently. For example, a patient with bipolar disorder who has co-existing asthma or inflammatory bowel disease may need their treatment plans altered to avoid or reduce the use of steroids.

Allergies Ask if the patient has any **allergies** and if so, clarify **what kind of reaction** they had to the substance (e.g. mild rash vs anaphylaxis

DRUG HISTORY

Ask if the patient is currently taking any prescribed medications or over-the-counter remedies:

“Are you currently taking any prescribed medications or over-the-counter treatments?”

If the patient is taking prescribed or over the counter medications, document the medication name, dose, frequency, form and route.

Ask specifically about injectable medications, as patients may be on depot medications (e.g. depot antipsychotics).

Ask about recent medication changes, as dose changes may precipitate new issues. For example, an anti-psychotic medication dose reduction may trigger a relapse of symptoms, or the metabolism of medication may be affected by enzyme inhibitors and inducers.

Ask the patient if they’re currently experiencing any side effects from their medication:

“Have you noticed any side effects from the medication you currently take?”

Commonly prescribed psychiatric medications

Anti-depressants

Selective serotonin reuptake inhibitors (SSRIs): sertraline, citalopram, escitalopram, fluoxetine

Serotonin-noradrenaline reuptake inhibitors (SNRIs): venlafaxine, duloxetine

Mirtazapine

Tricyclic antidepressants (TCAs): amitryptiline, nortriptyline

Mood stabilisers

Lithium

Sodium valproate

Carbamazepine

First-generation (typical) antipsychotics

Chlorpromazine

Flupentixol

Haloperidol

Levomepromazine

Zuclopenthixol

Second-generation (atypical) antipsychotics

Amisulpride

Aripiprazole

Clozapine

Olanzapine

Quetiapine

FAMILY HISTORY

Ask the patient if there is any family history of psychiatric or physical disease:

“Have any of your parents or siblings had problems with their mental health in the past?”

“Do you know what type of mental health problems they had?”

“Do any medical problems run in the family?”

For physical health problems, it is important to ask about diabetes, cardiovascular conditions, or any genetic conditions

PERSONAL HISTORY

In the personal history, you are aiming to get an understanding of the patient’s life experiences and the impact they may have had on them. It may be easiest to structure this chronologically, starting in childhood and moving on to education and employment.

1. ***CHILDHOOD -*** Ask the patient about their childhood:

“Do you know if there were any problems during your mother’s pregnancy with you?”

“Are you aware of any problems around your birth?”

“As far as you know, did you meet the normal milestones growing up?”

“How would you describe your childhood?”

The environment someone grows up in significantly impacts their personality and mental health as an adult. Childhood abuse, in particular, is associated with most psychiatric disorders.

If they report difficulties during childhood, try to find out more about this, acknowledging that it may be difficult for them to discuss**.**

2. ***SCHOOL AND EDUCATION***

Ask about schooling and education:

“Did you enjoy school?”

“Did you have a lot of friends at school?”

“Did you have any problems with bullies at school?”

“At what age did you leave school?”

“What qualifications did you leave school with?”

Explore whether they enjoyed primary and secondary school. If they didn’t, was it because of difficulty with schoolwork? Or something else in the school environment, such as relationships with teachers or bullying.

If the patient attended college and university, you should also ask about that experience and what they studied. How they coped at university can be very informative, as it may be the first time in someone’s life that they were responsible for managing things like finances and deadlines without support from family.

3. ***OCCUPATION***

Ask the patient about their occupation and employment history:

“Are you employed at the moment?”

“How long have you been at your current jobs?”

“What jobs have you had in the past?”

“Why did you leave your previous jobs?”

“Have you ever been dismissed from a previous job?”

An employment history can give a surprising amount of relevant information in the psychiatric history.

If a patient is currently employed, how they cope at work gives a good indication of their current level of function. For example, mania is more likely to impact a person’s work than hypomania.

If a patient has had multiple short-term episodes of employment or has been unable to maintain any period of employment, it suggests a significant impact on function.

4. ***RELATIONSHIPS***

Try to establish the patient's **current** and **previous interpersonal relationships**, and make sure to ask about relationships with family and friends and those of a romantic nature:

- *"How do you get on with your family?"*
- *"Do you find it easy to make friends?"*
- *"Do you feel like you have a good social support system?"*
- *"Are you in a romantic relationship at the moment?"*
- *"What have your previous romantic relationships been like?"*
- *"Have your current problems affected your relationships?"* (Romantic or social)

When asking about family, you should establish who is in their **immediate family**, their childhood circumstances, and how they would describe their relationship with their family, both in the past and now. It is also worth asking about any **recent significant events** in the family, as this may have **triggered** the patient's presentation.

The patient's relationship history can give clues to a diagnosis, and their current relationships will be relevant to their ongoing management (for example, having a supportive partner tends to contribute to better outcomes). A longstanding pattern of **multiple turbulent relationships** may suggest borderline personality disorder, or a pattern of **gradual social withdrawal** may suggest an illness like schizophrenia.

Although it can be challenging to ask about and discuss, it is also important to screen for any **experience of sexual abuse** at some point during a psychiatric assessment. However, particularly sensitive discussions may be better left until a later stage when rapport has been established unless it is significantly related to the presenting complaint.

5. PRE-MORBID PERSONALITY

Asking about pre-morbid personality helps understand how the patient's personality and behaviour patterns have changed over time – from asking the patient directly and from a collateral history. It's an extremely important part of a psychiatric history and should not be overlooked, as it will significantly impact diagnosis and care planning.

"How would you describe yourself?"

"How would others describe you?"

"Do you think this would have changed at all recently?"

"Do you have any hobbies or interests?"

"Are you religious?"

After some initial open questions asking the patient to describe themselves, you should conduct a structured enquiry about different personality traits (emotional, cognitive and behavioural):

Emotional traits: would they describe themselves as happy or sad? Do they experience mood swings? How do they manage anger?

Cognitive traits: how is their self-esteem? Are they a confident person? Do they see themselves as an optimist or pessimist? Are they naturally suspicious of others? How do they cope with decision-making?

Behavioural traits: would they describe themselves as an introvert or extrovert? Would they say they are impulsive? Do they enjoy socialising?

SOCIAL HISTORY : The social history is arguably one of the most important parts of a psychiatric history, as social circumstances are often significant risk factors for developing psychiatric conditions.

Living Circumstances : You should ask about the patient's current living circumstances:

"Where do you live currently?"

"Do you live with anyone else?"

"Are there any children at home?"

Homelessness

If a patient discloses that they are currently homeless, you should find out more information. Why did they become homeless (e.g. a problem with finances)? How long have they been homeless? Do they have access to hostels, or are they sleeping on the streets?

45% of homeless people in England have been diagnosed with a mental health condition, and there is a much higher prevalence of mental health problems in the homeless population compared to the rest of the population2.

Homelessness can both be caused by and cause mental health problems, so it is essential to include accommodation in your assessment and management plan

You also need to ask about any children at home to ensure they are still being cared for and in case any safeguarding issues arise from the assessment.

Activities of Daily Living: Asking about how a patient is managing their activities of daily living helps to assess the impact of an illness and will affect the types of treatment offered.

“5How are you coping at home at the moment?”

“Do you feel able to look after yourself?”

“Do you have any worries at the moment?”

If not already covered elsewhere in the history, you should ask about diet and what they are eating now, whether they are managing to maintain personal hygiene, or having difficulty managing housework and any financial concern.

Smoking : Record the patient’s smoking history, including the type and amount of tobacco used.

Alco