Department of Psychiatry

Kasturba Medical College, Mangalore

Case History Proforma

Hospital No.:

Date:

Name:

Sex:

Age:

Education:

Occupation:

Socio-economic Status:

Marital Status:

Informant: name and relationship

Reliability of information: Reliable/ not reliable (consistency, continuity and corroborated)

Adequacy of information: adequate/ not adequate (enough to arrive at a differential diagnosis)

Source of Referral:

Reason for Referral:

Chief Complaints:

Write 4 to 5 of the most significant complaints, with duration and chronological order- what started first will be mentioned first.

For eg., if the patient says, "I really feel sad and down in the dumps most of the time wherever I go and not interested to talk to people" then you need to mention:

- Sadness since 2 months
- Disinterest in social interaction since 1 month

History of Presenting Illness:

Onset: (time from first symptom to diagnosable clinical picture)

- Abrupt (within 2 days)
- Acute (within 2 weeks)
- Insidious (within a month or more)

Course:

- Continuous (no significant symptom-free period)
- Episodic (2-month period of near-normal functioning established between two or more episodes)
- Fluctuating (cannot classify it as either episodic or continuous)

Precipitating factor: Record significant biological or psychosocial factors which might be a triggering factor for the onset of illness.

Detailed description of each of the chief complaints in chronological order. (Describe how and when it started, progression, the behaviours pertaining to symptoms, any aggravating and relieving factors, diurnal variation if any, what did the patient and the informant do about it, any treatment taken, response of treatment, what made them consult now).

Though the information can be gathered from patient and the informants separately wherever appropriate, it should all be organised and reported in a coherent manner under this heading. Suppose there is discrepancy in the history/ about the complaints between the patient and the informant, then that is also recorded together mentioning how they reported it differently.

Generally, the history of presenting illness starts by saying: Patient was apparently normal till 2 months back, when he started feeling sad. (build up from there in chronological order elaborating each complaint.

At the end check about sleep, appetite, bowel, bladder and sexual function (biological function); social interaction with family, friends, colleagues (social function) and occupational function (at work/home). Mention medicolegal issues if any.

Conclude the history with a typical day of the patient since onset of symptoms and reason for presenting at this point.

Negative History:

Rule out the symptoms of likely differential diagnosis which are not present in this patient

Also mention Neurological and medical symptoms that may be associated with the likely diagnosis

Example:

No history suggestive of significant head injury/ loss of consciousness/ seizure/ progressive memory deficits

No h/o use or abuse of any kind of psychoactive substance

No h/o hearing voices or seeing things that others cannot see/hear

No h/o pervasive and/or persistent sadness

No h/o excessive cheerfulness /irritability

Treatment history-

Drug given, dosage, duration of treatment, response and improvement, side effects, reasons for stopping if any

Tabulate with time line if records available

Drug Name	Dosage	Duration	Response/ Improvement	Side effects	Reason for discontinuation
Olanzapine	20 mg	6 months (nov 2020 May 2021)	80%	Weight gain, sedation	Weight gain

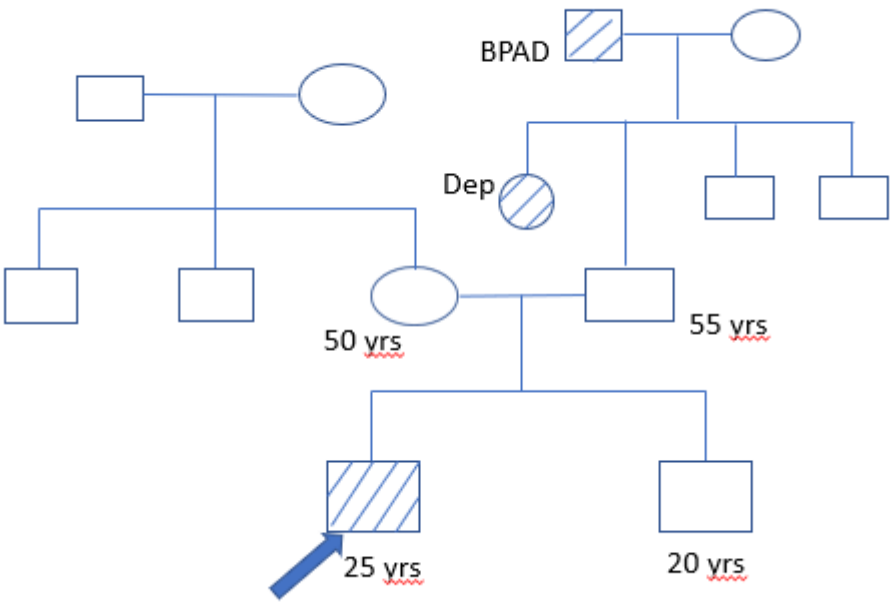
Past History:

Past History of **Psychiatric** Illness: Similar symptoms or any other psychiatric illness in the past. Mention treatment details if available

Past h/o **Physical** Illness like seizures, neurological illness, hypertension, cardiovascular disease, diabetes, thyroid abnormalities and any other.

Family History:

3 generation genogram



Family h/o psychiatric disorder

Family h/o medical disorder: Diabetes, Cardiovascular, neurological and any other illness

Living arrangements: nuclear/ joint family, urban/ rural,

Social support:

Financial support & socioeconomic status:

Expressed emotions in the family:

Personal History:

Birth and Development:

Childhood History: Schooling, Home atmosphere in childhood and adolescence, Presence of Childhood disorders

Occupational History:

Menstrual history: Menarche, cycle duration and flow, any problems, LMP

Marital History: Age at marriage, duration of marital life, details of family of procreation, any discord/conflicts

Sexual history: gender identity, sexual orientation, knowledge about sexual practices, whether sexually active or not, high risk behaviour, use of contraception.

Habits: Alcohol/ smoking in non-dependent pattern

Premorbid Personality / Temperament: (Information majorly gathered and corroborated with the informant):

Premorbid Personality (above 18yrs):

Social relations: (with family, colleagues, partner)

Intellectual Activities: (hobbies and interests)

Predominant Mood:

Character: (attitude to work and responsibility; interpersonal relationships; moral and religious attitudes and standards))

Energy and initiative:

Reaction patterns to Stress and coping:

Fantasy Life:

Habits: (sleep, appetite, bowel, bladder, biological rhythm)

Temperament (below 18 years):

Persistence and Attention span

Distractibility

Activity level

Adaptability

Quality of mood

Threshold level

Approach/ withdrawal

Rhythmicity

MENTAL STATUS EXAMINATION (as on _____mention the date)

1. **General Appearance and behavior:**
   - Appearance and grooming, its appropriateness to the situation, personal cleanliness:
   - Rapport:
   - Eye to eye contact:
   - Attitude towards examiner: (i.e. cooperative, guarded, playful, etc.)
   - Manner of relating: (i.e. relaxed, tense, over familiar, aggressive, disinhibited, withdrawn)
   - Body build (to record weight and height if required):
   - Facial expression and posture:
   - Motor behavior: (repetitive behaviors, tics, tremors, catatonic symptoms)

2. **Psychomotor Activity:** (increased/ decreased/ normal)

3. **Speech:** tone (loudness), tempo (speed), volume (amount), prosody, reaction time, relevance (relevant to question), coherence (understandability)

4. **Speech Sample:** 5 minute speech sample, neutral topic, verbatim (can record with permission and write down)

5. **Thought:**
    - Form
    - Stream
    - Possession: Obsession and thought alienation
    - Content (overvalued ideas, delusions, ideas of worthlessness, hopelessness, helplessness, death wish, suicidal ideas, suicidal plan, suicidal attempt)

6. **Mood and Affect:**
    - Subjective,
    - Affect (Objective, cross sectional)
    - Range,
    - Reactivity,
    - Lability
    - Appropriateness
    - Congruence

7. **Perception:**
    - Distortion
    - Illusion
    - Hallucination

8. **Cognitive Function:**
    - Consciousness:
    - Orientation: (time/ place/ person)
    - Attention and Concentration: (Digit span forward/backward, Serial subtraction 100-7)
    - Memory: (immediate/ Recent/ Remote)
    - Intelligence: General information; Language (spontaneous speech and fluency, comprehension, naming, reading and writing); Calculation (addition, subtraction, multiplication, division)
    - Abstraction: (dissimilarities/similarities/proverb interpretation)

9. **Judgement:** (Test/ Personal/ Social)

10. **Insight:** (Grade 1 to 6)
    - Awareness
    - Attribution
    - Acceptance

Diagnostic formulation:

Sociodemographic details, relevant premorbid, personal, family, past history, presenting complaints and duration, positive findings of general physical examination and mental status examination

Diagnosis:

Differential diagnosis:

Investigations/ Assessments:

Treatment plan: