CHAPTER II

SIMPLE CLASSIFICATION OF PSYCHIATRIC DISORDERS

Brief Schema for Psychiatric History-taking
Outline for Psychiatric Examination
Psychiatric Assessment Sheet
A SYSTEM OF CLASSIFICATION

Simple Classification of developmental approach.

1. Disorders primarily due to failure of mental development:
   a) Amentia: In this group failure of normal development is most evident. The patients are labelled as mentally subnormal. This can be classified into severe, moderate or mild mental subnormality. For example:
      1. Mongolism
      2. Cretinism
      3. Other Biochemical Anomalies.

   b) Immature personality: Primarily emotional and not necessarily accompanied by any intellectual deficiency.
      For example:
      1. Psychopathic Personality
      2. Hysterical Personality
      3. Other forms of Personality disorder

   c) Anomalies of Instinct:
      1. Homosexuality
      2. Sexual Perversion
      3. Drug & Alcohol Dependence.

2. Disorders primarily due to abnormal development or reaction to internal or external stress, i.e. secondary to infection, exhaustion, structural and physiological changes as well as emotional experience.

   (1) Functional Neurosis:
      (a) Hysterical reaction
      (b) Obsessive Compulsive reaction
(2) Affective Disorders:
   (a) Anxiety State
   (b) Depressive Illness
   (c) Mania
   (d) Hypomania

(3) Schizophrenic Psychosis.
(4) Acute Confusional state and other Psychiatric emergencies.
(5) Psychiatric Emergencies:
   (a) Attempted Suicide
   (b) Acute Hysterical state
   (c) Acute Psychosis, Confusion, Delerium, Schizoid reaction
   (d) Acute Alcoholic Psychosis
   (e) Puerperal Psychosis
   (f) Psychosomatic reactions
   (g) Dementias

Child Psychiatry is separately classified. It differs from general Psychiatry in certain clinical and therapeutic possibilities. Basically they share the same foundation with the parent subject as that of paediatrics with general medicine.
A USEFUL CLASSIFICATION OF PSYCHIATRIC CONDITIONS IN GENERAL PRACTICE

FORMAL PSYCHIATRIC ILLNESS:

1. Psychosis (schizophrenia, manic-depressive psychosis, organic psychosis)
2. Mental Subnormality
3. Dementia (deterioration of mental powers in excess of normal ageing process)
4. Neurosis (anxiety state, depressive, hysterical, phobic or neurasthenic reactions, others)
5. Personality disorder.

PSYCHIATRIC-ASSOCIATED CONDITIONS:

6. Physical Illness ) where psychological mechanisms have
7. Physical Symptoms ) been important in the development
) of the condition.
8. Physical Illnesses
9. Physical Symptoms ) which have been elaborated or pro-
) longed for psychological reasons.
10. Other Psychological or Social problems.

The place and circumstances of the examination should be indicated, e.g. in-patient unit, emergency clinic.

When the history is obtained from an informant, this should be recorded separately and not incorporated into the patients’ account.
A. Patient’s name B. Age C. Occupation D. Marital Status E. Address F. Source of referral.

1. REASON FOR REFERRAL.

This should be a succinct indication of the symptoms or events which led to the present examination. Reporting the events in the patient’s own words can be of much value, because of the fact that they reflect accurately how the patient himself perceives his complaints. The statements under this heading summarize how it came about that the patient was presented for psychiatric examination. The dates of onset should be clearly indicated. This short statement will be amplified under «Present Illness».

2. FAMILY HISTORY.

Under this heading the patient’s father, mother, siblings and other relatives living in his parental home should be described. Finally, the atmosphere of the home should be described, the financial, social and emotional circumstances, and the interpersonal conflicts and satisfactions should be enumerated which characterised the family as a unit.
Father: Age, health (including psychiatric disorder, alcoholism) or the age of death, its cause and patient’s age at the time. Occupation and personality.

Mother: Age, health (including psychiatric disorder, alcoholism) or age of death, its cause and patient’s age at the time. Occupation and personality.

Siblings: Enumerated in chronological order of birth, with christian names, ages, marital condition, personality, occupation, health or illness. Miscarriages and stillbirths to be included.

Home Atmosphere: Any salient happenings among parents and collaterals during patient’s early years. Emotional relationship to parents, siblings, nurse, etc. Note particulars which might be required for further study, e.g. names of hospitals where relatives have been treated.

PERSONAL HISTORY:


II. Infancy: Delicate or healthy baby. Time of teething, walking, talking, age of bowel control and parental attitudes. Disturbance of milestones.


V. School: Age of beginning and finishing. Standard reached. Evidence of ability or backwardness. Special abilities or disabilities. Hobbies and interests. Relationship to schoolmates. (nicknames, bully or butt.) Attitude to teachers. Attitude to work. Aims and ambitions (self and family).

VI. **Further Education:** Apprenticeship, technical training, University and professional training.

VII. **Occupations:** (In full detail) Age of starting work. Jobs held, in chronological order, dates, reasons for change. Present economic circumstances. Ambition. Satisfaction in work or reasons for dissatisfaction.

VIII. **Anti-Social Behaviour:** Delinquency and criminal offences. Drug abuse.

IX. **Service, war experience or military training:** Army service, duration, overseas experience, combat, P.O.W. medical or psychiatric discharge. Disability pension.

X. **Home Circumstances:** Accomodation, sharing of rooms, number of people in house. Financial circumstances.

XI. **Sexual History: Puberty:** Age of onset, mental reaction, how information acquired, masturbation (age, frequency, guilt, transient homosexuality, crushes, sexual fantasies, inhibitions, attitude to sex (prudishness, frankness). In females, age menstruation began, preparation for it, reaction to it. **Menstrual History:** Regularity of periods, pain tension. Onset of menopause, and climacteric symptoms. Sexual inclinations and practice: Masturbation, homosexuality; heterosexual experience apart from marriage; venereal disease; abortions.

XII. **Marital History:** Duration of acquaintance before marriage and of engagement. Husband’s (of wife’s) age, occupation, personality, compatibility. Frequency of sexual intercourse, sexual satisfaction or rigidity. Contraceptive measures. Marriage forced by pregnancy. Fidelity of partners.

XIII. **Children:** Chronological list of children and/or miscarriages (including abortions), giving names, ages, personalities, etc. of former. Attitude towards children. Psychiatric states of children.
4. PREVIOUS ILLNESS:

I. **Somatic:** Describe, chronologically and in detail, illnesses operations and accidents.

II. **Psychiatric:** Detail all psychiatric conditions for which treatment has been received giving dates, duration and nature of treatment given, in which hospital or out-patient department, or by which doctor. Detail all psychiatric symptoms for which treatment has not been received (e.g. hysterical disturbances, preoccupation with bodily functions, insomnia, mood variations, psychosomatic disturbances, obsessional anxiety and subjective tension symptoms, etc.)

5. PREVIOUS PERSONALITY:

The examiner assesses the patient's personality in two ways. First he obtains a detailed account of the patient's relationships with the other people with whom the patient customarily interacts, at home, at work and in social activities. Secondly, the examiner studies the way in which the patient reacts to him in the interview situation.

Personality is commonly described under the following headings: in this description of the personality prior to the beginnings of the mental illness, do not be satisfied with a series of adjectives and epithets, but give illustrative anecdotes and detailed statements. Aim at a picture of an individual, not a type. The following is merely a collection of hints, not a scheme:

I. **Social Relations:** To family (attachment, dependence); to friends (groups societies, clubs); to work and workmates (leader, follower, organiser, aggressive, submissive, adjustable). Friends: few and close; few and superficial; many and close; many and superficial. Prefers own sex. Prefers opposite sex.

II. **Activities and interest enjoyed:** books, plays, films. Quality of observation, judgement, critical faculty. Spends leisure time alone.

III. **Mood:** Cheerful, despondent, anxious, worrying optimistic, pessimistic, self-depreciatory, satisfied, over-confident, stable, fluctuating (with or without any occasion); controlled demonstrative.
IV. **Character Traits:** timid, sensitive, suspicious, resentful, quarrelsome, irritable, impulsive, jealous, selfish, egocentric, reserved, shy, self conscious, strict, fussy, rigid, lacks confidence.

V. **Attitudes and values:** moral, religious, social political, economic, practical. Attitudes towards self, others, health, own body.

VI. **Initiative:** Energy, output sustained or fitful. Fatiguability. Decisive, Effectiveness. Ambition.

VII. **Fantasy life:** Day-dreaming, frequency, content.

VIII. **Habits:** Eating, (fads), sleeping, excretory functions; Alcohol Tobacco, drugs; specify amount taken recently and earlier.

6. **HISTORY OF PRESENT ILLNESS.**

**THE MENTAL STATE.**

This is the systematic and objective assessment of the patient’s mental functioning as evident to the examiner in the course of the examination. (The history had dealt with the sequence of life experiences of the patient, leading up to and including the development of his illness).

1. **GENERAL BEHAVIOUR:** Description as complete, accurate, and lifelike as possible, of what we and the nurses observe in the patient’s behaviour, especially anything abnormal.

The following points may be considered, though not exclusively: Does the patient look ill? Is he in touch with his surroundings in general and in particular? Relationship to other patients, to the nurses, to the doctor who examines and treats him. How does he respond to various requirements and situations? What gestures, grimaces or other motor expressions, mannerisms. Much or little activity? Is it constant or abrupt or fitful? Spontaneous and how provoked? Free or constrained? slow, stereo-typed, hesitant, or fidgety? Tenseness, scratching or rubbing. Do movements and attitudes have an evident purpose or meaning? Do real or hallucinatory perceptions seem to modify behaviour? Does the patient, if inactive, resist passive movements, or maintain an attitude, or obey commands or indicate awareness at all? Eating, sleep, cleanliness in general, and excreta. Way of spending the day.

If the patient does not speak, the description of his mental state may be limited to a careful report of his behaviour.
2. TALK: The form of the patient’s utterances rather than their content is here considered. Does he say much or little, talk spontaneously or only in answer, slow or fast, hesitantly or promptly, to the point or wide of it, coherently, discursively, loosely, with interruptions, sudden silences, changes of topic, comments on happenings and things at hand, appropriately, using strange words or syntax, rhymes, puns? How does the form of his talk vary with its subject?

SAMPLE OF TALK: Conversation should be recorded with physician's remarks on left side of page, and patient's on right. It should be representative of the form of his talk, his response to questioning and his main preoccupations. Its length will depend on its individual significance. In later sections of the mental state, it will be desirable to record the patient’s reported experiences (e.g. hallucinations, delusions, attitude to illness) in his own words, but the sample required at this point need not aim at being comprehensive.

MOOD: The patient’s appearance may be described, so far as it is indicative of his mood. His answers to «how do you feel in yourself?» «what is your mood?» «How about your spirits?» or some similar enquiry should be recorded. Many varieties of mood may be present -not merely happiness or sadness, but such states as irritability, suspicion, fear, unreality, worry, restlessness, bewilderment, and many more which it is convenient to include under this heading. Observe the constancy of the mood, the influences which change it; the appropriateness of the patient’s emotional state to what he says. Thought content and nature of dominant thoughts. Are they gloomy or optimistic?

Delusions and Misinterpretations: What is the patient’s attitude to the various people and things in this environment? Does he misinterpret what happens, give it special or false meaning, or is he doubtful about it? Does he think anyone pays special attention to him, treats him in a special way, persecutes or influences him bodily, or mentally, or ordinary or scientific or preternatural ways? Laughs at him? shuns him? Admires him? Tries to kill, harm, annoy him? Does he depreciate himself in any regard, his morals possessions, health? Has he grandiose beliefs? These matters may be complicated or concealed and may need much enquirey. If a whole conversation dealing with them is reported here, resume the main points at the end.
Hallucinations and other disorders of perception: Auditory, visual, olfactory, gustatory, tactile, visceral. The source vividness reality, manner of reception, content, all other circumstances of the experience are important; its content, especially if auditory or visual must be reported in detail. When do these experiences occur, at night, when falling asleep, when alone? Any peculiar bodily sensations, feeling of deadness? Unreality?

Compulsive Phenomena: Obsessional thoughts, impulses, or acts. Are they felt to be from without, or part of the patient’s own mind? Does their insistence distress him? Does he recognise their inappropriateness? Relation to his emotional state? Does he repeat actions, such as washing, unnecessarily to reassure himself?

Orientation: Record the patient’s answers to questions about his own name and identity, the place where he is, the time of day, and the date. Is there anything unusual to him in the way in which time seems to pass?

Memory: This may be tested by comparing the patient’s account of his life with that given by others, or examining his account for intrinsic evidence of gaps or inconsistencies. Information which he gave about his previous life, his personality, sexual experiences, etc should not be inserted here but included as a supplementary part of the history, and its source indicated. There should be a special enquiry for recent events such as those of his admission to the hospital and happenings in the ward since. Where there is any selective impairment of memory for special incidents, periods, recent or remote happenings, these should be recorded in detail, and the patient’s attitude towards his forgetfulness and the things forgotten specially investigated.

Record the patient’s success or failure in grasping, retaining, and being able to recall spontaneously or on demand three or five minutes later a number, a name and address, or other data. Give him digits to repeat forward, and then others to repeat backwards, and record how many he can repeat immediately after being told.

(In describing the state of the patient’s memory, do not merely record the conclusions reached but give the evidence first, in full, and describe at appropriate length such facts of behaviour as seem to indicate whether he was attending, trying his hardest, being distracted by other stimuli, etc).
Attention and Concentration: Is his attention easily aroused and sustained? Is he easily distracted? Pre-occupied? To test his concentration ask him to tell the days of the months in reverse order, or to do simple arithmetical problems requiring «carrying over» (112-25), subtraction of serial sevens from 100 (give answers and time taken).

General Information: Tests for general information and grasp should be varied according to the patient’s educational level and his experiences and interests, but the answers to the following should be recorded in all cases.

Name of the Prime Minister
Date of the beginning and end of war.
Familiarity with recent events.

Intelligence: Assess the patient’s intelligence. Use his history his general knowledge, problems of reasoning. You may employ standardised tests. Observe discrepancies in the results of various methods, and try to interpret them.

Insight and Judgement: What is the patient’s attitude to his present state? Does he regard it as an illness, as «mental» or «nervous», as needing treatment? Is he aware of mistakes made spontaneously or in response to tests? How does he regard them and other details of his condition? How does he regard previous experiences, mental illness, etc.? What is his attitude towards social, financial, domestic, ethical problems? Is his judgement good? what does he propose to do when he has left the hospital?

INTAKE SUMMARY.
(This should not generally exceed one sheet of A4 in length)

This should be written as soon as a satisfactory informant has been interviewed, or at the latest within two weeks of the patient’s admission. It should be under the headings: 1. Reason for referral; 2. Family History; 3. Personal history; 4. Previous Illness (Psychiatric and physical); 5. Previous personality; 6. Present Illness. 7. Mental state; 8. Initial formulation.

CONFERENCE AND WARD-ROUND NOTES.
Whenever the patient is presented at a conference, the doctor will summarize the presentation and discussion, giving the data, and setting out in more detail the recommendations made and the conclusions reached.
TRANSFER OR TERMINATION.

When the treatment ends, or the patient is transferred to another ward or doctor, a brief summary is made. This is to summarize the illness, the treatment, progress of the case, and present clinical status; final diagnosis, degree of symptomatic improvement, and disposition of the case should then be stated.

CONSULTATION:

Whenever a consultant is called in to give a specialist opinion about some aspect of a case, the question put to him about the patient is to be recorded under the relevant date and a note made of his recommendation.

DISCHARGE SUMMARY.


DISCHARGE/LETTER TO PATIENT’S DOCTOR.

This may be brief and be accompanied by a copy of the summary, or where more appropriate may be more lengthy and not accompanied by a summary.

CLINICAL TESTING OF INTELLECTUAL FUNCTION.

(Not social or behavioural function)

ORIENTATION.

1. Date - am/pm/Day/Date/Month/Year
2. Place - Hospital? Home? (i.e. not the name but the nature.)
3. Person - What do I do? What does she (i.e. nurse) do?

ATTENTION / CONCENTRATION:

4. Days of week backwards
5. Months of Year backwards Progressive
data difficulty
6. 'Carrying over' sum eg. 112-25
7. Serial 7's
MEMORY SHORT TERM:
8. Place name eg. «St. Francis Hospital» «Dr. House»
9. Fictitious name & address 'John Brown'
   42 West St. Liverpool'
10. 6 figure number «183729»

LONG TERM:
11. Date of birth   Age
12. Home address   (Preservation often shows here)
13. Monarch/Prime Minster
14. Dates of WWI/WWII

LANGUAGE FUNCTION:
(check vision 1st)
15. Write your name and address
16. Object naming (pen, keys, yale key, stethoscope)
   increasing difficulty.
17. Reading a passage. What does it mean?

VISUO-SPATIAL FUNCTION:
18. Watch dressing
19. Obeying commands - «When I put my pen down»
   put on your glasses» etc.
20. Design copying

NB. This is not a «test» for which there is a «score». It is a clinical search for areas of disability.
A BRIEF SCHEMA FOR PSYCHIATRIC HISTORY TAKING

REASON FOR REFERRAL.

1. Circumstances eg GP referral to outpatients, emergency admission domiciliary visit.
2. Presenting complaints in patient’s own words

At this stage it may be appropriate to proceed to a history of the present illness, or to continue with format as presented. This schema represents the outline for the recording rather than for the taking of a psychiatric history.

FAMILY HISTORY:

1. Parents: Age, health, occupation. Patient’s observations as to parent’s relationship with each and their behaviour as parents.
2. Siblings: Age, names, health, occupation. Patient’s observations as to general family atmosphere in early years, and current relationships.
3. Other relatives: who live nearby or are emotionally significant.
4. Family medical history: especially details of psychiatric care.

PERSONAL HISTORY.

1. Pregnancy/labour: major difficulties; prolonged hospitalisation.
2. Infancy: medical problems, milestones; periods of separation.
3. Childhood/adolescence: education - standard reached; type of schools; attendance problems.
   contact with agencies - social service, child guidance, psychiatrist.
   Antisocial behaviour - police trouble; drugs; institutional care; relationship with peers.
4. Adult: Age of leaving school/parental home
   brief job history/further education history
   current home circumstances, finances, job.
5. Marriage: age, duration of courtship; personal details of spouse
   current relationship - children ages, names; problems (as above).
6. Sex: Rarely appropriate to ask for other than recent changes in
   interest.

PREVIOUS ILLNESSES.

1. Physical
2. Psychiatric - include dates and location of specialist contacts;
   overdoses; specific treatments (drugs, ECT, psychotomony, etc).

PERSONALITY.

1. hobbies, pastimes, social network
2. Character traits and usual mood state
3. Use of alcohol, tobacco, other drugs.
   If specific attitudes or beliefs (religious, political etc) are voiced
   spontaneously; allow patient to expand on them.

HISTORY OF PRESENT ILLNESSES.

1. Onset - date when where you last well
   - precipitants - apparent from history, or perceived by
     patient ie. other events going on at the same time.
   - gradual or sudden.
2. Course - Fluctuating, stable
   - slow progress, rapid, rapid decline etc.
   - response to previous treatments or circumstances
3. previous similar esipides
4. Treatment - all treatments given by others during this illness,
   including dosages. Current treatment, nature and
   duration.
5. Circumstances finally leading to presentation - deterioration
   insistence of Gp or family etc...
AN OUTLINE OF THE MENTAL STATE EXAMINATION.

GENERAL BEHAVIOUR:

(i) Appearance: clothes; make-up; cleanliness; attention paid to presentation.

(ii) Movement: spontaneous; restricted, bizzare; reflecting anxiety

    Social skills: eye-to-eye contact; friendliness.

SPEECH:

1. FORM: Rate, spontaneity; coherence etc. If at all abnormal quote a verbatim sample
2. CONTENT: Reflecting mode of responding to questions, preoccupations, etc.

MOOD:

1. Subjective: patients description of mood and its variations with time. Include here descriptions of anxiety (somatic & Psychic) and biological symptoms of depression, anorexia, weight loss, insomnia, early morning waking, etc).
2. Objective: Tearfulness; agitation or manifest anxiety; marked variability; modification by content of interview.
3. Suicidal ideas: including specific plans.

OBSESSIONALITY:

1. Ideas, thoughts, images: repetitive, intrusive, resisted, recognised as inappropriate.
2. Rituals: washing, counting, checking.

DISORDERS OF PERCEPTION.

1. Distortions - illusions; depersonalisation; deja vu.
2. Hallucinations - describe exact content; mental state and level of consciousness at the time; patients awareness at the time of the unreality of the experience.
DELUSIONS AND MISINTERPRETATIONS.

CLINICAL TESTING OF INTELLECTUAL FUNCTION

(Not social or behavioural function)

ORIENTATION
1. Date - Am/PM/Day/Date/Month/Year
2. Place - Hospital? Home? (ie. not the name but the nature)
3. Person - What do I do? What does she (ie. nurse) do?

ATTENTION/ CONCENTRATION.
4. Days of week backwards
5. Months of year backwards
6. «Carrying over» sumeg.112-25
7. Serial 7's

Progressive difficulty

MEMORY: Short Term:
8. Place name eg. «St. Francis Hospital» «Dr. House»
9. Fictitious name & address «John Brown» 42 West St. Liverpool'

LONG TERM: 10. 6 figure number «183729»
11. Date of birth Age
12. Home address (preservation often shows here)
13. Monarch/Prime Minister
14. Dates of WWI/WWII

LANGUAGE FUNCTION: 15. Write your name and address
(check vision 1st) 16. Object naming (pen, keys, yale key, stethoscope) increasing difficulty
17. Reading a passage. What does it mean?

VISUO-SPATIAL FUNCTION:
18. Watch dressing
19. Obeying commands - «When I put my pen down, put on your glasses» etc
20. Design copying.

N.B. This is not a «test» for which there is a «score». It is a Clinical search for areas of disability.
SAMPLE
CASE REPORT

(Name) ____________________________________________

(date) ____________________________________________

Medical Student to ____________________________________________

Introduction
I saw Mr. Gordon Bennett at the city hospital where he had been admitted on the previous day having taken an overdose of aspirin.

Clinical Summary
Mr. Bennett a 59 year old with no previous psychiatric history. He is married with two children in their late teens and works as a coalminer in Hucknall. He has been under some stress this year, with short-time working at the pit and with worry over his elder son, who was cautioned for shop-lifting in January and whom he suspects has recently started illicit drug use. Three months ago he went to his GP with complaints of anxiety and insomnia and was started on a benzodiazepine hypnotic. For two months prior to presentation he had significant biological symptoms of depression. When seen he was agitated and tearful, and expressing ideas that he was inadequate as a father to his children and as a provider to his family.

Formulation:
This is the first presentation with a major depressive illness of a middle-aged man who has been under financial and family stress recently.
Management:

Mr. Bennett was admitted to the ward informally and treated with antidepressant and ECT. I interviewed his wife when she came to visit him and discussed the case with the social worker, who visited the family at home to assess the problem with the children.

Follow-up:

Mr. Bennett responded well to a short course of ECT and was discharged to the outpatient clinic with no significant symptoms. Our social worker arranged to follow the family up to help with what appeared to be temporary adolescent behaviour problem in the younger boy.

PSYCHIATRIC EXAMINATION SHEET.

Date .................................................. No. ..................................................
Address ............................................. Name ..............................................
Occupation ........................................Nationality ......................................
Children ........................................... Marital Status ..................................

Diagnosis

Result

HISTORY

1. Source & Cause of Referral

2. Complaint
   A. Patient
   B. Informant
   C. Attendants.

3. History of present illness (detailed & chronological: any precipitating cause either physical such as influenza or psychological such as bereavement, quarrels, troubles; any change in behaviour, habits, sleep, appetite, etc)
   Duration Onset Course
4. Personal (past) history:

A. Medical History:
   1. Previous attacks of a like or unlike character (detailed)
   2. Record all illnesses (fevers, operations, … etc)

B. Developmental date:
   1. Birth history (age & health of mother during pregnancy labour, attitude or parents & whether wanted or attempted abortion, parent’s feelings regarding the sex of child)
   2. Infancy history (feeding, weaning, teething, sitting, walking, sphincter control, illnesses esp. convulsions chorea).
   3. Childhood & adolescence (health, any traumatic events, social adaptation, neurotic traits, antisocial traits)

C. School History:

D. Work Record:

E. Psychosexual of Development (detailed)
   1. 1st awareness of sex, how?
   2. Masturbation
   3. Heterosexual, homosexual inclinations, sexual fantasies
   4. Marital history (circumstances of marriage, characteristics of both mates, mode & frequency of sexual satisfaction or frigidity or impotence, any contraceptive measures & concern aroused by their use, any family problems)
   5. Menstrual history, pregnancies & abortions:

F. Personality traits before illness:
   1. Social life, including hobbies, interests, interpersonal relationships:
   2. Mood
   3. Character & moral:
      Any addiction to drugs (alcohol, hashish, opium, hypnotics & if alcoholic state the exact amount, the nature of alcohol & duration of the habit)
   4. Family History:
      A. Parents (health, age & cause of death, occupation & personality):
B. Sisters, siblings & other relatives (their personality traits).
C. Children (ages, occupation, personality traits).
Any nervous or mental disease:
Interpersonal relationships of family members:
Home atmosphere (step-parents? dissention between parents, economic conditions, sleep-arrangements, parental over solicitude or over-severity, stress on religion).

EXAMINATION

A. PRESENT MENTAL STATE.

1. General appearance & behaviour (accessible or negativistic conditions of dress & toilet, expression of face, gait posture and voice, bodily movements)
2. Stream of talk (form, i.e. stammer or lips, amount & rate)
3. Mood (excesses or deficiencies, constant or changeable appropriateness)
4. Perception
   (a) Hallucinations (type, source, time of occurrence & contents)
   (b) Illusions:
      Ideas of reference:
      Illusions of unreality (derealization, depersonalization).
5. Thought process (obsessions & compulsions, delusions, passivity feeling, familiarity and unfamiliarity feelings, dreams and nightmares etc).
6. Consciousness (confusion, stupor) & orientation for time, place and person:
7. Memory:
   (a) future events (appointments)
   (b) Recent events (events of the past 24 hours, repeat name, address, flower after 3-5 minutes, retention of digits)
   (c) Remote events (birthday, date of marriage)
      Test for retention & recall (same tests as for recent events)
      Hypermnesia:
      Paramnesia - Confabulations
8. Attention & concentration (ask pt. to tell the days or months in reverse order, digits to repeat forwards and backwards).

9. Scholastic and General Knowledge:
   a. Name of Prince
   b. Facts of geography (capitals of Egypt, Iraq, England)
   c. Fact of history.

10. Calculations (exp. for Egypt, Iraq, England)
    100-7 & then subtract 7 consecutively
    100 Joffray’s sing 123
    \[ \begin{array}{c}
    7 \\
    \hline 8
    \end{array} \]
    \[ \begin{array}{c}
    81624
    \end{array} \]

11. Intelligence

12. Judgement

13. Insight (awareness of illness, opinion of nature of illness. prepared to cooperate with treatment)

14. Evidence of brain damage (aphasia, acalculia, agraphia, apraxia)

B. PHYSICAL EXAMINATION

C. SPECIAL INVESTIGATION

1. Lab:

2. Psychological Tests:

D. DIAGNOSTIC FORMULATION

E. TREATMENT

F. RECOMMENDATIONS