1 The psychiatric history

Psychiatric history	Case example
Introduction and presenting complaint	***Introduction and presenting complaint:*** Mr John Smith is a 36 year old Caucasian gentleman, who was admitted to Florence Ward three days ago, after police detained him on Section 136 acting bizarrely in the street. He was assessed in A+E and placed on a Section 2. His main concern is that his neighbours are plotting to kill him.
History of Presenting complaint	***History of presenting complaint:*** Mr Smith reports that he last felt free from worry four months ago. Since this time, after witnessing the man next door staring at him when he was out, he has become increasingly concerned about the activities of this neighbour and his wife. He believes they are intercepting his mail, and have a machine to do this so noone can tell letters have been opened. He often sees red cars outside which he thinks are used by these neighbours to monitor his movements. He smelt a "strange gas" in the flat recently and concluded they had pumped this through holes in the ceiling. In the last week he reports things have escalated and after an altercation on the street three days ago in which he accused these neighbours of pumping gas into his flat, he realised that they want to kill him. He believes they want to force him to leave the house so they can purchase the property for their expanding family. He denied feeling low in mood, and is more angry about the situation. He cannot rule out the possibility he might defend himself if he felt threatened by the neighbours, but denies specific plans to retaliate against the perceived persecution. He denies hearing the neighbours or others talking about him or feeling that they can control him or his thoughts. He has been sleeping poorly due to worrying about the situation. His appetite is good.
Past Psychiatric history	***Past psychiatric history:*** Mr Smith has seen a psychiatrist once before, aged 8, when he was diagnosed with "emotional problems". His GP diagnosed depression when he was 24, and prescribed Fluoxetine which he never took. He believes he was depressed for a couple of years in his mid-twenties but denies mental health problems since then. No previous psychiatric admissions. He has never taken medication for mental illness.
Past medical/surgical history	***Past medical/surgical history:*** Mild asthma. Nil else of note.
Drug History and Allergies	***Drug history and allergies:*** No current medication. No known allergies.
Family history	***Family history:*** His father died from lung cancer aged 60 when Mr Smith was 28. His mother and brother (eight years younger) live near by. Both are well, in regular contact and supportive. No known family psychiatric history.
Personal history	***Personal history***
Early life and development	***Early life and development:*** Mr Smith was born by Normal Vaginal Delivery, with no known complications. There was no developmental delay. The family lived in the same house in Doncaster throughout his childhood. His father was a computer salesman, and his mother was a housewife. He believes his parents were happily married, and there were no financial problems at home. At the age of 6 his maternal grandmother and grandfather died in a car crash. He remembers this as an unhappy time, and recalls being left on his own to play for hours on end. Two years later his brother was born and the years after this were happier. He denies mental or physical abuse.
Educational history	***Educational history:*** Mr Smith left school at 16 with 5 GCE's. He had good friends from school. He was often in trouble with his teachers, was suspended once for cheating in an exam, but was never expelled.
Occupational history	***Occupational history:*** After leaving school he worked in the family plumbing business for a few years, before leaving to train as a mechanic. He completed his training and has worked as a mechanic since this time. He has never been sacked, and has been in his current job for three years, which is his longest period of consecutive employment; he has a good relationship with his employer. He has been on sick leave for the last two weeks due to stress.
Relationship history	***Relationship history:*** Happily married for 10 years. He has one daughter, aged 5 who is well.
Substance use	***Substance use:*** Mr Smith drinks 30 units of alcohol a week, mainly wine in the evenings. There is no history of alcohol dependence. He has used cannabis regularly in the past (aged 16-28) but no illicit drug use since this time.
Forensic history	***Forensic history:*** One conviction for driving without due care in 1990, for which he received a fine. No other arrests or convictions reported.
Social history	***Social history:*** Mr Smith owns his three bedroom detached house. He has friends from his cycling club who he usually sees weekly, although not for the past month. He works fulltime in a garage. No current financial difficulties.
Premorbid personality	***Premorbid personality:*** He described himself as being a sociable, calm person who thought the best of people and didn't tend to get into disputes with others prior to his current difficulties. He is a keen cyclist and member of a local cycling club, and attends church weekly. He obtains comfort from this and has some friends with whom he socializes at parish functions.
Informant history	

Taking a psychiatric history and assessing the mental state (discussed in Chapter 2) are undertaken together in the ***psychiatric interview***. As well as systematically obtaining this information, it is crucial to establish and maintain a rapport with the patient. In this chapter and the next, we present a format for written documentation; greater flexibility is clearly required during the actual interview.

Introduction and presenting complaint

Begin your history with a brief ***introduction***, including the patient's name, age, occupation, ethnic origin, circumstances of referral and presenting ***complaint*** (in the patient's own words).

History of the present illness

When did the problem begin, or if the person has a longstanding, relapsing, remitting illness, when were they last well? Ask about perceived precipitating factors, the effect on personal relationships and their capacity to work. What does the patient think might have caused the illness as a whole or this relapse/recurrence, and what makes it better or worse?

Especially in psychosis, the patient's view of events might differ from those of their family, friends or other collateral sources. In this case, you can record their account, followed by any collateral information available.

Depending on the presenting complaint, you will need to ask follow-up questions about other symptoms to help you make a diagnosis. Your questions should be guided by the diagnostic criteria for the individual disorders (discussed in later chapters). For example, if the patient describes feeling anxious, you would ask questions to establish if the anxiety is situational and if panic attacks occur. You should usually enquire about mood, sleep and appetite, even if they appear normal, and whether there are risks to self or others (see Chapters 4 and 5).

Previous psychiatric history

Give dates of illnesses, symptoms, diagnoses, treatments, hospitalizations, including whether they have been treated under compulsory admission or treatment.

Past medical/surgical history
Drug history and allergies

Include psychotropic medications which the person has received previously, their dosage and duration, and whether or not they helped. The patient or family may not have this information and it may be necessary to obtain it from the patient's GP or hospital notes.

Family history

Note parents' and siblings' ages, occupations, physical and mental health, and quality of their relationship with the patient. If a relative is deceased, note the cause of death and the patient's age at the time of death and their reaction to that death (see Chapter 10). Ask about family history of psychiatric illness ('nervous breakdowns'), suicide, drug and /or alcohol abuse, forensic encounters and medical illnesses.

Personal history

Early life and development

Include details of the pregnancy and birth (especially complications), any serious illnesses, bereavements, emotional, physical or sexual abuse, separations in childhood or developmental delays. Describe the childhood home environment (note atmosphere, any deprivation).

Educational history

Include details of school, academic achievements, relationships with peers (did they have any friends?) and conduct (whether suspended or expelled). Bullying and school refusal or truancy should be explored.

Occupational history

List job titles and duration, reasons for change, work satisfaction and relationships with colleagues. The longest duration of continuous employment is a good indicator of pre-morbid functioning.

Relationship history

Document details of relationships and marriages (duration, details of partner, children, abuse); sexual practices, difficulties and orientation; in the case of women, menstrual pattern, contraception, miscarriages, stillbirths and any termination(s) of pregnancy. Those who are in a long-term relationship should be asked about the support they receive from their partner and the quality of the relationship – whether there is good communication, aggression (physical or verbal), jealousy or infidelity.

Substance use

Alcohol, drug (prescribed and recreational) and tobacco consumption.

Forensic history

Note any arrests, whether they resulted in conviction and whether they were for violent offences. Report any periods of imprisonment, for what they were imprisoned and the length of time served.

Social history

Describe current accommodation, occupation, financial details and daily activities.

Premorbid personality

A description of the patient's character and attitudes before they became unwell (e.g. character, social relations). You could ask the patient how they would describe themselves before their current difficulties and how their friends would describe them; what they enjoy doing; how they cope with adversity; whether they practise any religion and if they get comfort from this, or details of social contacts with religious or other groups/organisations.