

PSYCHIATRIC HISTORY TAKING TEMPLATE

Resident Documentation Template | Structured Clinical Assessment & Intake Guidelines

1. PATIENT DEMOGRAPHICS
• Patient Name: <i>[First Last]</i> • Age: <i>[Age] years old</i> • Marital Status: <i>[Single / Married / Partnered / Divorced / Widowed]</i> • Dependents Status: <i>[Children (number/ages), elderly relatives, or none]</i> • Living Situation: <i>[Who do they live with? (e.g., alone, family, roommates) Where? (e.g., house, apartment, shelter, facility)]</i> • Employment Status: <i>[Employed (full-time/part-time) / Unemployed / Student / Retired / Disability]</i> • Means of Finance (if unemployed): <i>[Disability benefits, family support, government assistance, savings, none]</i>

2. CHIEF COMPLAINT (CC)
<i>"[Patient's verbatim statement regarding reason for presentation or referral]"</i>

3. HISTORY OF PRESENT ILLNESS (HPI) & SCREENING

• **Current Presentation:** *[Detail the onset, duration, nature, and evolution of current psychiatric symptoms leading to this intake.]*

• **Main Concern:** *[What is the patient's primary complaint or issue they are seeking help for?]*

• **Why Now?:** *[What specific event, acute symptom exacerbation, or threshold was crossed that brought the patient in today?]*

[Identify recent or ongoing psychosocial precipitants (e.g., relationship loss, financial strain, job loss, medical illness, trauma).]

• **Depression Screen (DSM-5 Criterion A):** *2 weeks or longer of sustained low mood or loss of interest/pleasure (Anhedonia)*

• **Mania / Hypomania Screen:** *Elevated, expansive, or irritable mood with abnormally increased energy (≥ 4 days for hypomania, ≥ 1 week or hospitalization for mania).*

• **Psychosis Screen:** *Hallucinations (auditory/visual), delusions, thought disturbances (insertion/blocking), or disorganized speech/behavior.*

• **Anxiety Screen:** *Uncontrolled worry or excessive anxiety occurring most days for at least 6 months.*

• **OCD Screen:** *Intrusive unwanted thoughts (obsessions) or repetitive behaviors/mental acts (compulsions) causing marked distress.*

• **Substance Use Screen:** *Problematic pattern of substance use leading to clinically significant impairment or distress.*

Safety Assessment:

- **Suicide Risk:** *Passive vs. active ideation? Intent? Plan? Access to lethal means? Preparatory steps? Prior attempts (recency, method, motive, feelings towards survival)? Protective factors (family, beliefs, goals)?*

- **Homicide / Violence Risk:** *Ideation, intent, targeted individuals, access to means, motivation? (Revenge, obsessional/delusional thoughts) history of aggressive behavior/ previous criminal record?*

4. PAST PSYCHIATRIC HISTORY

- **Past Psychiatric Diagnoses & Admissions:** *[First contact with mental health, diagnoses, treatment if known/ admissions/ ED visits, adherence, last follow up, current providers]*
- **Previous Management Trials:** *[List trials, dosages, durations, efficacy, adverse side effects, reason stopped/started, LAI formulations, neurostimulation.]*

4. PAST PSYCHIATRIC & FAMILY HISTORY

- **Family Psychiatric History:** *[Psychiatric diagnoses, hospitalizations, family history of suicide, substance use disorders.]*

5. PAST MEDICAL HISTORY & ALLERGIES

- **Past Medical & Surgical History:** *[Chronic medical conditions, surgeries, head trauma, loss of consciousness, seizures, active medical issues.]*
- **Current Medications & Supplements:** *[Medication name, dosage, frequency, adherence, prescribing provider.]*
- **Allergies:** *[Medication allergies, environmental allergies, and type of adverse reactions.]*

6. PERSONAL & DEVELOPMENTAL HISTORY

- **As a Child:** *[Family structure, parents' occupations, born where, milestones, perinatal history, childhood home, relationship with parents, siblings, peer relationships/friends, physical/emotional/sexual abuse history]*

- **As a Teen:** *[Friends/social network, romantic relationships, school performance/attainment, extracurricular activities, sexual history, trouble/disciplinary issues, relationship with parents, physical/emotional/sexual abuse history]*

- **As an Adult:** *[Work history, financial status, highest education, adult relationships, family structure, goals for future, overall trends in functioning]*

- **Strengths & Stressors:** *[Coping skills, hobbies, personal strengths, current social supports, ongoing environmental stressors.]*

- **Forensic History (Always Ask):** *[Legal issues, arrests, charges, convictions, sentencing/incarceration history, probation/parole, outstanding debts/obligations.]*

7. MENTAL STATUS EXAMINATION (MSE) & COGNITION

- **Appearance:** *[Cleanliness, grooming, dress appropriateness, apparent age vs. stated age]*
- **Behavior:** *[Eye contact, psychomotor agitation/retardation, cooperativeness, involuntary movements]*
- **Speech:** *[Rate, rhythm, volume, tone, articulation, latency]*
- **Mood (Self-reported):** *[Patient's self-described emotional state in quotes, e.g., "Good", "Sad", "Anxious"]*
- **Affect (Observed):** *[Quality (e.g., euthymic, dysphoric), range (full, constricted), appropriateness, stability]*
- **Perception:** *[Auditory/visual hallucinations, illusions, depersonalization, derealization]*
- **Thought Process:** *[Linear, goal-directed, circumstantial, tangential, flight of ideas, loose associations]*
- **Thought Content:** *[Delusions, obsessions, preoccupations, suicidal/homicidal ideation, paranoia]*
- **Cognition / Sensorium:** *[Alertness, orientation, concentration, memory (short/long-term), language]*
- **Insight & Judgment:** *[Awareness of illness, understanding of need for treatment, decision-making capability]*
- **MMSE / Folstein Screen Prompt:** *Orientation (Time/Place) | Registration & Delayed Recall (3 words) | Attention (Serial 7s / WORLD) | Language (Naming, Repetition, 3-Stage Command, Copying pentagons)*

8. DIAGNOSIS/ DIFFERENTIAL

DSM-5 Diagnosis:

- **Primary Diagnosis:** *[Primary DSM-5 Disorder, code, severity]*
- **Secondary / Differential Diagnoses:** *[Other psychiatric conditions under consideration]*
- **Medical Conditions:** *[Relevant non-psychiatric diagnoses]*

9. IMPRESSION/ SAFETY ASSESSMENT

- **Clinical Impression:** *[Synthesize biological, psychological, and social contributing factors, clinical reasoning, precipitating triggers, and summary of presentation.]*

Safety Assessment (If Risk Present):

[Prompt: Evaluate Suicide Risk (ideation, intent, plan, means, past history, protective factors), Harm to Others / Violence Risk, and Self-Neglect / Vulnerability. State overall risk level (Low / Moderate / High).]

9. PLAN & RECOMMENDATIONS

Reviewed with Dr. XXXXXX and discussed with patient, they were in agreement of following:

- 1. Safety Concerns & Mental Health Act:** *[Document safety management plan, level of supervision required, voluntary vs. involuntary status under Mental Health Act / form status if applicable.]*
- 2. Investigations:** *[List laboratory work (CBC, CMP, TSH, Vit B12/Folate, Urine Drug Screen, etc.), ECG, neuroimaging, or psychometric assessments.]*
- 3. Collateral:** *[Identify if further collateral information obtained or required (family, friends, outpatient providers, police/EMS reports).]*
- 4. Referrals:** *[List referrals to specialists, outpatient psychiatry, psychology/psychotherapy, social work, addiction services, occupational therapy.]*
- 5. Psychoeducation:** *[Document education provided to patient/family regarding: Treatment Plan | Management Strategy | Diagnosis | Sleep Hygiene | Exercise & Lifestyle Modalities.]*
- 6. Medications:** *[Detail pharmacological plan: continuation, initiation, dose adjustments, target symptoms, rationale, and consent obtained.]*
- 7. Disposition:** *[Document final disposition: Inpatient Admission, Outpatient Follow-Up (clinic date/time), Emergency Safety Instructions.]*