Psychiatry History Format and Diagnostic Formulation

Endorsed & Recommended by Indian Psychiatric Society (IPS) PG Education Subcommittee, IPS UG Education Subcommittee, Indian Teachers of Psychiatry (IToP) Forum - 2024-25

Psychiatry History Format and Diagnostic Formulation

Endorsed & Recommended by Indian Psychiatric Society (IPS) PG Education Subcommittee, IPS UG Education Subcommittee, Indian Teachers of Psychiatry (IToP) Forum - 2024-25

IPS UG Education Subcommittee, IPS PG Education Subcommittee and Indian Teachers of Psychiatry (IToP) Forum Consensus on Psychiatry History Proforma & Diagnostic Formulation

The committee met many times for deliberations and arrived at a consensus

The Deliberation Began With
Indian Psychiatric Society South Zone
Committee for Consensus on Psychiatry History Proforma & Diagnostic Formulation

Dr PSVN Sharma
Professor of Psychiatry & Former HoD, KMC, MAHE, Manipal
Chairman

Dr M Kishor
Professor of Psychiatry & HoD, JSSMC, JSS AHER, Mysuru
Co-Chairman

Representative Members from the Southern States
Dr K Raman
Professor of Psychiatry, Saveetha Medical College & Hospital, Chennai, Tamil Nadu

Dr Bheemsain Tekkalaki
Associate Professor of Psychiatry, JNM, KLE AHER, Belgaum, Karnataka

Dr Nimmy Chandran
Assistant Professor of Psychiatry, Government Medical College, Palakkad Kerala

Dr Raviteja Innamuri
Assistant Professor of Psychiatry, Govt Medical College, Nizamabad Telangana

Dr Adiseshamma Tiruvaipati
Professor of Psychiatry and HoD, Government Medical College, Ongole Andhra Pradesh

The Committee members requested respective state institutions, teachers, experts, and residents to submit their suggestions and proforma being followed.

The committee met many times for deliberations and arrived at a consensus

Report Submitted On 17th Oct 2024 at IPSOCON Bengaluru

Further, IPS Southzone led by President Dr Abhay V Matkar requested the consensus committee to present at IPSOCON Bengaluru on 18th Oct 2024 for delegates, which comprised psychiatry teachers and postgraduates, and consider the input. Subsequently, on 19th Oct 2024, IPS Southzone requested the committee to discuss with IPS UG Education Subcommittee and IPS PG Education Subcommittee at the National Level and consider a beneficial consensus for India. The Committee contacted Dr N M Patil, Chairman of IPS UG Education Subcommittee and Dr Henal Shah, Chairman of IPS PG Education Subcommittee. Both committees discussed among all stakeholders and deliberated with experts to provide valuable input on the consensus and agreed to endorse the document jointly. The Indian Teachers of Psychiatry (IToP) Forum considered the document and endorsed, the final document was prepared on 14th Jan 2025 and released at ANCIPS 2025 Hyderabad

Preamble

History elicitation and diagnostic formulation is at the very heart of clinical medicine. It is both a skill and an art. An informative and relevant history that communicates the patients' (clients') perceptions, cognitions, emotions, needs, fears & other concerns with fidelity, is essential for the clinician to understand the problems of the patient (client), accurately. This in turn will be useful in providing appropriate interventions to the patient/client.

The following proforma provides the bare minimum guideline for eliciting and organizing the patients' / client history under various headings. It is axiomatic that the mentor of the student will teach the latter how to customize the elicitation of history, depending on the needs of the clinical situation and the setting of its use. Hence these guidelines may be modified, altered or expanded as the case may be.

Although on initial viewing, it may appear that this document is lengthy, the student, with appropriate guidance and experience, will learn how to gather necessary information efficiently and fairly quickly.

Like all such documents, this too will need revision and updating over time, as dictated by progress in the professional field.

Psychiatry History Proforma

.

** The template of the Psychiatry History-Taking Proforma and diagnostic Formulation for the adult patient provided here may be considered a skeletal minimum standard for acquiring information. Trainees and teachers are, however, encouraged to expand on this in terms of categories for collecting information and the content of information collected, depending on the exigencies of the clinical situation. The digital format of history taking can be documented under various subheadings.*

1.Socio-demographic details:

Name, Age, Gender, Address, Education, Occupation, Religion, Socio-economic status, Martial status, Advance Directive, Nominated Representative.

2) Informant: Relationship to patient, whether they stay with the patient or not, duration of staying together, Reliable/ not reliable

(Reliability is determined by, consistency, confirmability, credibility, constancy and adequacy)

3) Presenting / Chief Complaint: (with duration in chronological order of appearance) in patient/ Informant's own words and the duration of each complaint is noted.

According to patient:	According to informant:
1.	1.
2.	2.
3.	3.

Onset: Abrupt/Acute/Subacute/Chronic

Course:Continuous/Progressive/Episodic/Fluctuating/Improving

Precipitating Factors (if any):

4) History of Presenting illness (HOPI):

Elaborate the presenting complaints either in chronological order or in the order of importance. Elaborate each symptom describing the ABCDEs (antecedent factor, behaviours, consequence, duration, episodic nature/ fluctuation).

Antecedent factors can include the explanation from patient /family member/care giver and interviewer's summative record based on information collected.

Quote the patient/informant's verbatim wherever possible.

Establish the impairment due to symptoms.

Add details about the substance use if any (especially when

it is not a case record about substance use disorder)

Diagnostic exclusionary history (negative history) should

be included as appropriate

(For beginners, separate HOPI as described by both patient and the attender can

be considered. However, after some experience the students can be encouraged to synthesize a single HOPI taking into account the separate descriptions).

5) Treatment history:

A summary of treatment past trials (for the episodic illness, the treatment taken for the current episode can be described here and the treatment details of past episodes can be discussed in past history) with emphasis on the medication maximum dose, maximum duration, adherence, clinical impact and adverse effects. Quality of life associated with compliance with treatment

The details of non-pharmacological therapies, like counselling and/or specific therapies, also neuromodulation therapies with the outcomes should also be documented. This section includes history of traditional and culturally sanctioned interventions, if any.

6) Past History:

A summary of previous episodes/ course of illness till now. In case of multiple similar episodes, describe one episode in detail, with a comment on inter-episodic functioning. Details of previous hospitalization if any.

Relevant Medical and surgical history can be incorporated.

A graphical description of previous episodes, with all treatment details, treatment response, interval period functionality can be designed at the institute level using a standard format, including details of treatment seeking behavior.

7. Family History

a. Family of Origin: Each family member (parents and siblings) is described briefly with respect to age, sex, education, occupation, health status,

relationship with the patient, substance use and abuse, age at death, mode of death.

Type of Family-nuclear/joint/extended. A 3-generation genogram should be depicted.

b. Family of Procreation: Details of patient's spouse and the children should be described using the same parameters described above.

c. Social situation: Home circumstances, per-capita income, socioeconomic status, leader of the family, family members with whom the patient is staying at present and current attitude of family members towards the patient's illness, mode of coping by the family, social supports – primary, secondary, tertiary.

History of any psychiatric/ medical illness, epilepsy/mental retardation/suicide in the family.

7) Personal History

a) Birth and early development:

The details of prenatal, natal and post-natal periods are recorded; was the birth at full term? Whether delivered in hospital or home? Any complications during delivery? Any physical illness in the post-natal period? Whether milestones of development were normal or delayed is ascertained.

b) Behavior during childhood:

Thumb-sucking, nail-biting, temper tantrums, bed-wetting, stammering, tics and mannerisms, features of conduct disturbances in the form of frequent fights, truancy, stealing, lying and gang activities, Relationship with parents, siblings, and peers, play behavior, impulsivity, restricted interests.

c) Physical illnesses during childhood:

Physical illnesses suffered in childhood, specifically regarding epilepsy, meningitis and encephalitis. Impact of the illness on the child and the family.

d) Family atmosphere during childhood/upbringing:

Parenting style, abuse, adverse childhood experiences in family setting. Attachment issues, if any.

e) Formal education

Age of beginning and finishing the school, type of school attended, scholastic performance, attitude towards peers and teachers, history of bullying, teasing, Level of education reached. Reasons for academic failure, if any.

f) Occupation:

Age of starting work, jobs held, in chronological order; work satisfaction, competence, future ambitions, whether changing jobs frequently, cause for such changes.

g) Menstrual history:

Age of menarche, regularity of menstrual cycles; Dysmenorrhea, menorrhagia/oligomenorrhea, history suggestive of Premenstrual Dysphoric disorder or Perimenopausal syndrome.

h) Sexual history: Age at onset of puberty; level of knowledge regarding sex and mode of gaining the same, masturbatory practices; Anxiety related to sexual fantasies.

i) Marital history: Age at the time of marriage, whether arranged by elders or self, consanguineous/non consanguineous. Was there mutual consent of the partners; Age, Education, Occupation, Health and Personality of partner, Quality of marital relationship (Physical and psychological), Any separation or divorce. Note the number of children, their ages and health status, education & marital status of children Remarriage, and Relationships outside marriage (wherever necessary).

8) Premorbid Personality:

Preamble

In this personality description before the beginning of the mental illness, the learner should not be satisfied with a series of adjectives and epithets, but give illustrative anecdotes and detailed statements. Information on the period between the morbid states and or before the morbid state is useful (Example- Premorbid time frame should begin in an individual not with mere use of substance but only from the time the individual meets the criteria for the

substance dependence) . Aim at a picture of an individual, not a type. The following headings are merely a collection of hints, not a scheme. It will not be possible to cover all the items listed in the course of the first interview, but an attempt should be made, particularly cases of anxiety or affective disorder, to elicit evidence about all aspects of pre-morbid personality in the course of explorations extending over a period. Wherever the illness has onset before adulthood, describe the pre-morbid temperament using the Thomas and Chess classification. It is advisable to keep in mind the anchor points ICD-11 provides in cases where one is dealing with a person with a possible personality disorder.

Subsections of Premorbid Personality

a) social relations: The family (attachment, dependence); to friends, groups, societies, clubs, to work and workmates (leader or follower, organizer, aggressive, submissive, ambitious, adjustable, independent etc). This section includes aspects of religiosity and spirituality that individual believes and /or follows in any.

b) Intellectual activities: Hobbies and interests - preferred books, plays and/or pictures etc

c) Mood: Bright and cheerful or despondent, worrying, tense or calm and relaxed; optimistic or pessimistic; self-depreciative or satisfied; mood stable or unstable with or without any occasion.

d) character:

i) Attitude to work and responsibility: welcomes or is worried by

responsibility, makes decisions easily or with difficulty; haphazard and careless or methodical and meticulous; Whether person is rigid or flexible; cautious, has foresight. Is he/she prone to repeated checking, Is he/she impulsive and acts too quickly, Is he/she persevering and determined, or easily bored and discouraged

Interpersonal relationships: Self-confident or shy and timid, insensitive or touchy and sensitive to criticism, trusting or suspicious and jealous, emotionally-controlled or quick-tempered and irritable, tactful or outspoken; enjoys or shuns self-display; quiet and restrained. Does he/she retain friends or keeps breaking relationships often, Is he/she tolerant or intolerant of others; adaptable or rigid.

ii) Energy &initiative: Energetic or sluggish, output sustained or fitful, fatigability, any regular or irregular fluctuations in energy or output.

9) General Physical Examination: Includes comprehensive documentation of physical examination

The MSE is documented in following format

https://indianpsychiatricsociety.org/wp-content/uploads/2023/11/MSE-final.pdf

Diagnostic Formulation

Preamble

A diagnostic formulation is a concise aspect of a patient's relevant information that includes a tentative explanation for the development of their disorder, a diagnostic classification, and a therapeutic plan. It can be based on a theoretical explanation (psychodynamic or any other etiological theories) of information gathered from a clinical assessment. The diagnostic formulation depicts the thinking of the clinician regarding the patient / client and his/her illness, keeping in mind his/her specific socio cultural, intellectual, familial, belief systems and knowledge background. It is also a reflection of the clinicians' knowledge base and how he/she makes the connections between what the patient /client experiences and their theoretical aspect and hence practical relevance. If done well, it is an indicator for the clinicians' thought process not only of the diagnosis but also the possible management plan(s). It should be noted that this is different from a summary.

**The template of the Diagnostic Formulation for the adult patient provided here may be considered a skeletal minimum standard. Trainees and teachers are, however, encouraged to expand on this, depending on the exigencies of the clinical situation.*

The diagnostic formulation is recommended to be documented only in scientific language and not in the patient/client narrative, precisely and in personalized manner. The diagnostic formulation should encapsulate only the relevant phenomenology of the individual, which is extracted from chief complaints of the individual to mental status examination and documented concisely unlike the summary. This includes aetiological analysis based on biopsychosocial aspects as the case may be. Significant physical examination findings are noted. Psychometric findings can be recorded. The documentation of diagnostic formulation usually ranges from 10-20 sentences without repetition of any aspect. The recorded information should be relevant for psychiatric diagnosis. Thus, it includes complete psychiatric diagnosis (provisional or differential as the case may be) and medical comorbidities. Any information not mentioned in the diagnostic formulation shall be considered not present or relevant for diagnosis and hence negative history should not be recorded