Psychiatric interview schedule

Psychiatric Interview
The diagnostic interview, like most tasks in life, has a beginning, middle, and an end. One of the secrets of a good interviewer is the ability to actively structure the interview in its three phases.

The opening phase includes meeting your patient, learning a bit about his life situation, and then shutting up and giving him a few uninterrupted minutes to tell you why he came.

Then you will map the interview according to your initial hypothesis of the diagnosis, you will behave with the psychotic patient in a different than with neurotic or depressed patient.

In the last part of the interview you have to assess your findings with your initial hypothesis.

Interview contents:

1-Identification of the patient: full name, age, gender, marital state, No .of children, educational level, occupation, residency, and religion.

2-Mode of referral: did the patient came by him, brought the family, referred by another medical staff, by the police or by the court.

3-Main compliant: the nature of the compliant and its duration, and should be mentioned by the patient’s words.

4-History of the present illness: when was the patient perfectly normal? When and how the illness started? Any predisposing factors or a direct cause? Was the onset abrupt or gradual? How the symptoms develop, any aggravating, or alleviating factors, any effect on social, occupational, and biological aspects. Draw a profile of the illness history.

5-Family history: this includes, parents, brothers, wife, children, his order among sibs, any psychiatric history among them, relationship among them, death and it's cause.

6-Personal history:

- Infancy and childhood: includes date and place of birth, was normal or difficult? Health at that time, any trauma, any delayed milestones, any neurotic habits, like thumb sucking, nail biting, or nocturnal enuresis. Relations with other children and playing.
- Schooling: what was the age of attaining the school? What is his educational level?, how was the school records, any history of school phobia or truancy? His relationship with his colleague and teachers.
• Occupations : what was his first job and at what age? Any change in his work and why?
• Sexual history : for the female ask about the menarche and the patient’s reaction. For the male what was the age of attraction to the other gender, age of first masturbation, the sexual fantasy, any sexual relationships?
• Marital history : when and how, the nature of the relation, No . and ages of children.
• Past medical and psychiatric history.
• Drug history.

7- premorbid history:

Social relationships, hobbies, believe, morality, and standards, and prominent mood.

8- mental state examination:

This should include full physical and neurological examination.

1. Appearance and behavior : does the patient look healthy or ill? clean or dirty, shelved and combed, tidy or untidy.

   Is the patient quiet? Restless, agitated?

   Is he cooperative?

   Is there any eye to eye contact?

   Any abnormal movement, like tremor chorea, or tics?

2. Speech : describe the stream of talking, mute, scanty talk, slow current, or rapid as in mania with pressure of speech. Are the content normal? Relevant to the questions or irrelevant? Is the talk coherent or incoherent? Give sample of the patient’s talk. Any abnormal words like neologism.

3. Mood : what is the patient’s subjective emotional sensation? Is he sad and tearful as in depression or happy, elated and exhilarated as in mania? Ask about suicidal and homicidal ideas. Is his mood combatable with his affect? In schizophrenia the affect could incongruent.

4. Abnormal experiences: as hallucination in schizophrenia, depression. Visual hallucinations occur in organic brain diseases, drug poisoning, schizophrenia, and depression, olfactory and gustatory usually found in TLE, and sometimes in schizophrenia. Tactile hallucinations usually found in schizophrenia.

5. Abnormal believes: grandiose and paranoid delusions may occur with patients of mania and schizophrenia. Delusions of guild, poverty, nihilism, may be found in depressed patients. Thought broadcasting, thought insertion, or ideas of references. Any obsessive ideas, sense of derealization?

7. Insight and judgment: is the patient aware of his illness? Give the patient a simple task like what he will do if he find a closed envelop near his house?

8. Cognitive functions:
   - **Concentration:**

     Check the concentration of the patient by asking him to count from 100 to 0 by subscribes 3 in each step, or to mention the days of the week retrogradly.

   - **Memory:**
     1. Immediate retention: give the patient five different digits repeat them until he retain them then ask him after 5 minutes to mention them.
     2. Recent memory: ask the patient about recent events like what his breakfast in the morning was, or how he came to the hospital?
     3. Remote memory: ask the patient about an important general event when it was and if he can mention any details.

   - **Orientation**

     This includes orientation for time, whether the patient can recognize it is a day or night, the approximate time, or sometimes the season. Orientation for place, if the patient can recognize where is he now. And orientation for persons, that he can recognize the people around him in their names and relation to him.

9- **Record your deferential diagnosis**