Appendix 11.

Expert Patient Programme Toolkit

Appendix 11. History taking checklist

Expert Patient Feedback Sheet

		Achieved: YES	Achieved: NO
1.	The presenting complaint is defined	☐	☐
2.	Details of the history of presenting complaint are taken. This will include a chronological history and details of symptomatology.	☐	☐
3.	Reasons for contacting psychiatric services and relevant precipitants ascertained.	☐	☐
4.	The patient's personal history detailed. This must include developmental milestones, early childhood development, school performance, qualifications and work record.	☐	☐
5.	A social history obtained which must include details of the patient's current accommodation, job and relationships, including formal and informal carers.	☐	☐
6.	Details of the patient's family history taken, to include any known family history of psychiatric illness.	☐	☐
7.	Previous contact with psychiatric services detailed, including relevant significant medical illnesses.	☐	☐
8.	The patient's current and past medication recorded.	☐	☐
9.	An alcohol history taken, specifying number of units consumed per week, plus any relevant symptoms of dependence and any other illicit drug use.	☐	☐
10.	A full mental state examination to be carried out, including **a)** appearance and behaviour (comment on) **b)** speech – form and content (comment on) **c)** mood (ask directly) **d)** thoughts (ask directly) **e)** perceptual abnormalities (ask directly) **f)** cognitive state examination (ask directly if pertinent, comment on if no obvious deficit) **g)** insight (ask directly)	☐	☐
11.	Details of any forensic history/contact with criminal justice.	☐	☐
12.	A brief description of possible aetiological factors should be included, with predisposing, precipitating and perpetuating factors.	☐	☐
13.	A full risk assessment should be made, paying attention to such issues as thoughts, planning, intent, previous attempts and protective factors.	☐	☐