Examination of the Patient with Psychiatric Complaints

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Evaluation

• Evaluation of Neuropsychiatric complaints including depression, anxiety, memory problems and related difficulties is a valuable and necessary skill for all physicians.

• Providing an outline for this type of evaluation will provide a learning framework for patient examination skills.
Evaluation Focus

- CC/HPI
- Screening questions
- General Medical History
- Family History
- Social History/Substance Use History
- ROS
- Physical Exam
- Differential Diagnosis
- Treatment Plan
HPI

• General Assessment
  – How did the symptoms start
  – How long
  – Alleviating or aggravating factors

• Screening for specific syndromes
  – Addiction (CAGE)
  – Depression (SIGECAPS, specific depression)
  – Other disorders
General Medical History

- Comorbid/contributing conditions
- Neuropsychiatric illnesses
- Many neuropsychiatric illnesses are recurrent.
- May include general response to treatment
Family History

• Neuropsychiatric Illnesses
  – Often have familial inheritance patterns.

• Other illness which may predispose
  – Cardiac illnesses and depression
  – CVD and depression or cognitive deficits
Social History

- Developmental History
- Educational History
- Work History
- Relationship History
- Legal History
Review of Systems/Allergies

• General screen for other symptoms
  – Comorbid or related conditions

• Allergies/Adverse Drug Reactions.
Physical Exam

• General Condition
  – Vital Signs

• General Physical Exam
  – Mental Status Examination (see MSE study guide)
Assessment

• Appropriately relating findings to the patient.
• Giving the patient an opportunity to clarify and/or ask any questions.
• Working Diagnosis/Differential Diagnosis.
  – Ex. MDD vs. dysthymia vs. Bipolar Depressed vs. substance induced mood disorder.
• Engaging the patient in consent to treatment (do they understand, demonstrate capacity)
Treatment Planning

• Pharmacotherapy
  – Basic medication groups (ex. antidepressants) and relative dosages.

• Psychotherapy
  – Can occur with any other therapy and often more effective in combination

• Appropriate Follow up.
  – Usually 2-4 weeks.
  – Based on safety, expected changes, chronicity etc.
Documentation

• SOAP format
• Subjective
  – History, screening, ROS
• Examination Data
  – Physical exam including Mental Status Exam
• Should follow the course of patient treatment
• Explain the process of treatment decisions.
Helpful Tips

• You do have time
  – Follow the complaints of the patient.

• Think about context
  – It should all make sense…not just a jumble of memorized questions.

• Make it relate to treatment of patients
  – The SP is designed to help you gain clinical knowledge and skills.