

Introduction to Psychiatric Assessment

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Designed as a quick-reference guide for students, trainees, and clinicians.

1. What Is a Psychiatric Assessment?

Aspect	Description
Definition	A systematic, structured interview and observation process used to gather information about a person's mental health, functioning, and psychosocial context.
Purpose	• Establish a working diagnosis • Determine severity and impact of symptoms • Identify risk factors (e.g., suicidality, violence) • Guide treatment planning and follow-up
Setting	Outpatient clinic, emergency department, inpatient unit, community mental health team, telepsychiatry.
Legal/ethical base	Informed consent, confidentiality, capacity assessment, duty to warn/protect.

2. Core Components of the Assessment

Step	Key Elements	Typical Questions / Techniques
A. Opening / Rapport	• Explain purpose, confidentiality, limits of confidentiality. • Obtain consent for assessment and possible recording. • Name, age, gender, preferred pronouns.	"Can I explain how this interview will work and what we'll do with the information?"
B. Identifying Data	• Date of birth, ethnicity, marital status, occupation, education, living situation. • Referral source and reason for visit.	"What brings you here today?"

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C. Presenting Problem	• Onset, duration, frequency, intensity, course. • Triggers, alleviating/aggravating factors. • Functional impact (work, relationships, self-care). • Past diagnoses, hospitalisations, treatments, response to medication/therapy.	“When did you first notice these symptoms?”
D. Psychiatric History	• History of self-harm, aggression, substance use. • Developmental milestones, childhood trauma, learning difficulties. • Chronic illnesses, surgeries, head injuries, seizures.	“Have you ever been admitted to a psychiatric unit?”
E. Medical & Neurological History	• Current medications (including OTC & supplements). • Allergies, family medical history. • Alcohol, nicotine, caffeine, illicit drugs, prescription misuse.	“What medicines are you taking right now?”
F. Substance Use	• Quantity, pattern, last use, withdrawal symptoms. • Psychiatric disorders in relatives, genetic predisposition.	“How often do you drink alcohol, and how many drinks each time?”
G. Family & Social History	• Social support, relationships, employment, legal issues, trauma exposure.	“Who lives with you and what is your relationship like?”

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H. Mental Status Examination (MSE)	Appearance – grooming, posture, eye contact.	
	Behaviour – psychomotor activity, agitation.	
	Speech – rate, volume, fluency.	
	Mood & Affect – subjective mood, observed affect.	
	Thought Process – linear, circumstantial, tangential.	Use open-ended prompts (“Tell me about your day”) and targeted probes (“Do you ever hear voices?”).
	Thought Content – delusions, obsessions, suicidal ideation.	
	Perception – hallucinations, depersonalisation.	
I. Risk Assessment	Cognition – orientation, attention, memory, executive function.	
	Insight & Judgment – awareness of illness, decision-making capacity.	
	• Suicide: ideation, plan, means, previous attempts.	