APPENDIX E

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DEPARTMENT OF PSYCHOLOGY

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Case History Outline

I Identifying data :

Name : Date & Place of Birth :

Age : Sex : Religion :

Marital Status :

Occupation :

II Statement of the Problem :

Name and address of the person who referred the case :

Nature of the disturbance
(A brief history of the evolution of the problem)

III Congenital and physical Factors

(A) Congenital factors : Put a (√) mark if present.

	In the person	Parents	Siblings	Relatives
Insanity.....				
Feeblemind dedness.....				
Epilepsy.....				
Glandular disorders.....				
Alchoholism.....				
Nervous breakdowns.....				
Instability.....				
Any other.....				

(B) Physical Factors (Developmental)

Condition of mother during pregnancy :

Nature of delivery :

Careful history of any birth injury

Childhood diseases (Course and any residual of each)

Accident :

Convulsion :

Fainting Spells :

Glandular disturbances :

Diseases of nervous system :

Nervous indigestion :

Prolonged sleeping spells :

Any others :

(C) Height and weight at the time of birth :

Age of walking :

Age of talking :

Age of teething :

Report of medical or physical examination :

(D) Reactions to cogenital physiological and environmental forces which may have influenced the present behaviour :

1. Emotions Reactions in early childhood :

Temper tantrums and how met by parents, signs of stubborness, suspiciousness, etc. Fear reactions, their origin and how handled by parents. Love reactions, attachment to parents, dependent, overaffectionate, shy, fearful. Thumbsucking, nail biting, masturbation etc.

2. Reactions in later childhood and adolescence :

Freedom of expression depending on parents. Emancipation from parental control. Attitude toward group activities, friendship etc.

IV Environmental Forces or Situations :

(A) Family Constellation :

1. Father; age, occupation, religion, family background, outstanding personality traits or characteristics, relationship to other members in the home.

2. Mother; Age, occupation, religion, the family and personal back-ground characteristics of and relationship with other members of the family.

3. Siblings and Children : Age, sex, relationships and characteristics differences in degree of favouritism.

4. Other members : Those who entered or left the family circle and their characteristics and relationships to the patient.

(B) Physical Conditions in the Home :

1. A brief chronological account of home life from birth to present time, including changes in residence, foster-home placement or the like. Orderliness, cleanliness, regularity, sleeping arrangement, facilities for recreation, etc.

2. Methods of controls and supervision ; Matters of discipline duties and responsibilities at home.

(C) Community and Cultural Factors :

Nationality and religions background of the patient. Extent of participation in religious, social and political activities, economic and social status of the family in the community, extent to which family has accepted the dominant community culture.

(D) Educational Factors :

Age of entering school, college or university schools, colleges and university attended, grades repeated or skipped, any special difficulties in school subject. Attitudes toward teachers, subject liked most, extra-curricular activities, evidence of leadership, rank in class, educational plans and ambitions.

(E) Occupational Factors ;

Jods held and presently holding, reasons for changing jobs, date of change, vocational interests and ambitions, the determinants of such interests, special skills.

(F) Recreational Factors ;

Nature of leisure time activities, kinds of activities enjoyed membership in clubs etc., hobbies or special interest.

V The Mental Status Examination :

(A) Appearance, General Behaviour and Attitude :

Observation of patients appearance, activity, manner of dressing motor behaviour, facial expressions, mannerisms, patients accessibility, his attitudes toward the interview situation and toward the subjects under discussion, some of the physiological concomittants of behaviour such as tenseness, tremors, dilated pupils, flushing, sweating, rapid pulse etc.

(B) Contents of Thought;

Peculiar, unusual or overvaluated ideas, misinterpretations of reality, delusions with varying degrees of systematization, illusions (sensory misinterpretation) and hallucinations, feelings of unreality and depersonalization, obsessions and compulsion, phobias, any other.

(C) Emotional Status (or State of Emotional Activity)

What the patient says about his inner feelings and his overt expressions (including physiological concominants) as well as the resonance or feeling aroused in the examiner by the patient.

1. Prevailing mood such as cheerfulness, gloominess, anxiousness along with the depth or extent of changes,
2. Consistency or ability of mood
3. Appropriateness of emotional responses to the expressed mental content.

VI The State of Sessorium and Intellectual Capacities :

Patients contact with his environment.

(A) Orientation :

1. For time : The hour of day, week and the month.
2. For place : Particular building, town, state,
3. For person : Recognition of status of people about

(B) Memory :

1. Immediate : Ability to retain and immediately recall a series of digits and a name, address, object and colour after a five minutes interval.
2. Recent : Ability to relate events in the recent past (dates of symptoms, names of physicians, recent activities, etc.)
3. Remote : Name of schools attended, occupations, etc.

(C) Grasp : Hypothetical problems, such as apparently complicated but essentially simple arithmetic problems can be used. Knowledge of current events and their meaning.

(D) Intelligence :

Estimates through school achievement, general fund of information and vocabulary vocational achievements, evidence of skill and abilities as revealed in the job history.

(E) Judgement and Insight :

Ability of the patient to evaluate the relationship of event in the past, present or future to one another and to the total situation. The patients ability to reason, whether his premises are different from the usually acceptable ones and whether his behaviour supports his stated judgements, clarity and mental functioning, patients ability to evaluate his behaviour in terms of the total situation and also of more specific relationships.

VII Sources of Information :

(A) List of all the sources of information in order of importance, name, address and relationship to the patient, of each person furnishing the information :

(B) Impression of the Information :
Appearance, intelligence, personality, insight, attitude and cooperation, evaluation of the reliability and adequacy of information given, evaluation of informant's capacity, intellectually and emotionally to cooperate in a plan of treatment of the patient.

(C) List of all social agencies who have had contact with the family (relief, medical, psychiatric, and other agencies) and the history of the contact of each, report from agencies, indicating source in every case.