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Mental Health Nursing I&II

Practical/Clinical Record Book

Semesters V & VI

As per the Revised INC Syllabus for BSc Nursing

Name of the Candidate: _____

Name of the Institution: _____

_____

Manisha Gupta

2nd Edition

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2 UNIT

Assignment in Psychiatric Outpatient Department

Sl. No.	*Assignments*	*Quantity*
1.	Observation report	1
2.	History taking	2
3.	Mental status examination	2
4.	Mini mental status examination	2
5.	Health education	1

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OBSERVATION REPORT

Objectives

Functions

Physical Layout

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Departments and Clinics

Staffing Pattern

Organizational Pattern

Conclusion

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EVALUATION CRITERIA FOR OBSERVATION REPORT OF OUTPATIENT DEPARTMENT

Sl. No.	*Content*	*Marks allotted*	*Marks obtained*
1.	Objectives	5	
2.	Functions	5	
3.	Physical layout	3	
4.	Departments and clinics	2	
5.	Staffing pattern	5	
6.	Organizational pattern	3	
7.	Conclusion	2	
	Total	**25**	

Signature of the Supervisor

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HISTORY TAKING

Introduction

History taking is a fundamental process of collecting data for the investigation and treatment. The history is a picture of patient's development and adjustment during his life. It should contain relevant information on possible genetic and family influences on his personality and his illness. It represents the patient's development from childhood to adult life. It should provide evidence of adjustment to school, work, marriage, society together with a record of his physical and mental health, and previous personality.

History taking is better to understand if it is organized into identifying data, chief complaint, the present problem and past personal history. It is done by clinical interview. The interview allows the nurse to hear the patient's perspective on his problem.

Purposes

- To identify the data of the patient.
- To know chief complaint and present problems of the patient.
- To collect personal history of the patient.
- To identify the provisional diagnosis of the patient.

Skills

- Conduct the interview in a quiet place.
- Ensure privacy of the patient.
- Be relaxed and maintain an unhurried posture.
- Maintain eye contact with the patient.
- Be interested and attentive to what he says.
- Observe verbal and nonverbal cues of distress.
- Allow the patient to talk freely without any interpretation.
- When the patient deviates from the theme, guide him to verbalize with main theme.
- Use open ended questions.
- Use active listening.
- Do not offer premature conclusions and assurance on the outcome of the treatment.

Process

History taking proceeds through different headings as follows:

1. Identification and demographic data.
2. Presenting complaints/chief complaints.
3. History of present illness.
4. Past psychiatric history.
5. Family history and genogram.
6. Personal history.
7. Premorbid personality.

- **Identification and demographic data:** It includes the patient's name, age, sex, religion, address, socioeconomic status, marital status, occupation, education, mother tongue details of the informant.
- **Presenting complaints/chief complaints:** The symptoms are listed in a chronological order with their duration. The mode of onset of the illness may be acute or insidious. The progress may be steady and progressive, diminishing and reappearing periodically or staying the same way throughout these also should be checked. The chief complaint is a verbatim recording of the patient's reason for seeking treatment or evaluation or the presenting problem for which the client is seeking professional help. The chief complaints should be stated in the client's own words.

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- **History of present illness:** The patient's symptom noted since consultation to till date. Details of each symptom should be collected. It is in the patient's own words. It is a chronological description of how symptoms in the current episode have unfolded over time. History of present illness can be collected by the informant.
- **Past psychiatric history:** The patient had enquired any psychiatric illness in the past. It describes all previous episodes and symptoms, whether treated or not. Many psychiatric illnesses are familial and many of these appear to have a genetic component to the cause. If any past psychiatric illness found, enquire its nature, duration, treatment and outcomes.
- **Family history and genogram:** A family history represents a type of family, size and family environment. Family history include name of family members, relationship with patient, age, education, socioeconomic status, medical illness and mental illness. Genogram depicting the living members, their age, diseased members and death **(Fig. 2.1)**.

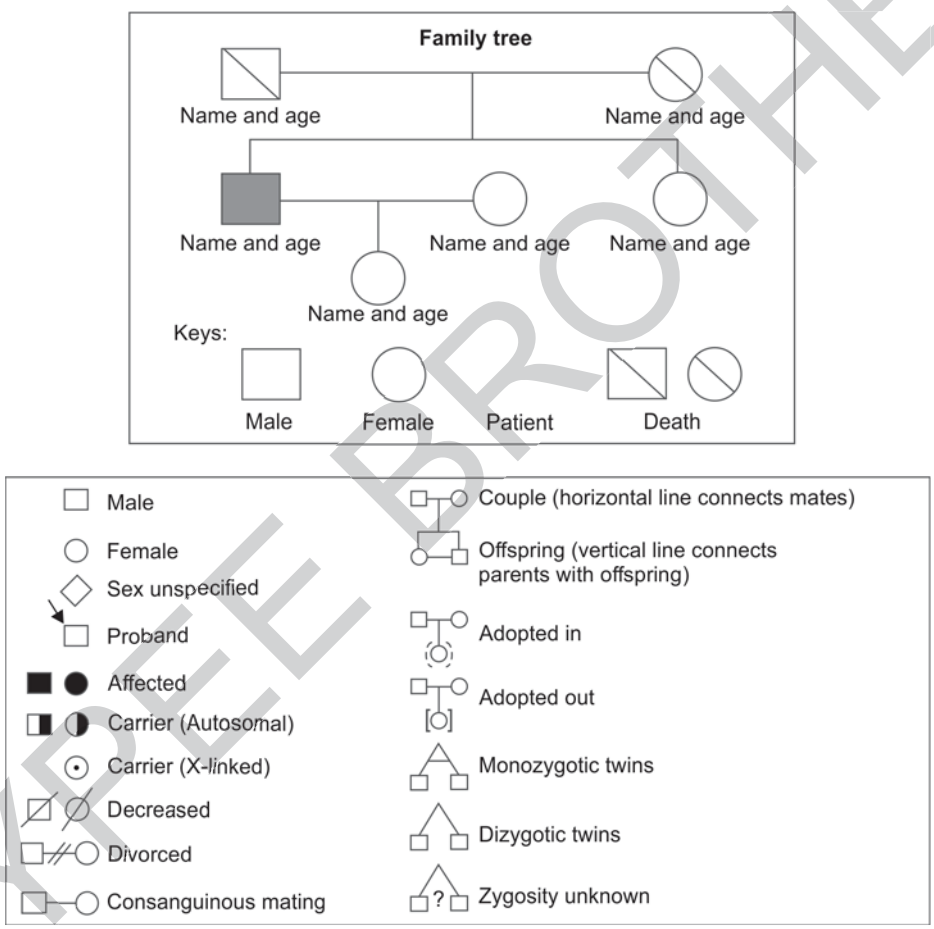

Fig. 2.1: Family genogram.

- **Personal history:** It describes significance throughout a person's life. The personal history include developmental history such as details of pregnancy and obstetric history, developmental milestones, infancy history, childhood history, adolescent history, adulthood history, marital history, sexual history.
- **Premorbid personality:** This personality of the individual is prior to illness. Premorbid personality consists of habits, hobbies, type of personality, family and social relationship, use of leisure time predominant mood, reaction to stressful events, attitude towards self and others, religious and moral, values, and fantasy life.

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HISTORY TAKING

I. Identification Data

Name _____ OP/IP No. _____

Father's Name _____ Unit & Bed No. _____

Age _____ Sex _____

Address _____

Mother tongue _____

Marital status _____

Living status _____

Religion _____

Education _____

Occupation _____

Brought by/informants _____

II. Present Chief Complaints (with Duration in Chronological Order, in Patient's/Informant's own Words)

_____

_____

_____

_____

III. History of Present Illness

Mode of onset _____

Course _____

Intensity _____

Precipitating factors _____

Detail description of present illness (chronological order) _____

_____

_____

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IV. Treatment History

Drugs (name of the drug, dose, route, side effects) _____

_____

_____

Electroconvulsive therapy (ECT) _____

Psychotherapy _____

Family therapy _____

Any other therapy _____

V. Past History of Illness

- **Past Medical/Surgical History**

  _____

  _____

  _____

  _____

- **Past Psychiatric History**

  _____

  _____

  _____

  _____

Number of previous episode with onset and course _____

Duration of each episode _____

Treatment details _____

Effects of treatment _____

Any substance abuse details _____

Detail description of history of past illness (chronological order) _____

_____

_____

_____

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VI. Family History

Sl. No.	*Name of the family member*	*Age/ sex*	*Marital status*	*Education*	*Occupation*	*Relationship with patient*	*Present health condition/illness*	*Any past psychiatric history*

Family Genogram

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VII. Personal History

- **Perinatal History**

  Antenatal period _____

  Intranatal period _____

  Birth _____

  Birth cry _____

  Any birth defects _____

  Postnatal complications _____

  Any other specify _____

- **Childhood**

  Primary care giver _____

  Feeding pattern _____

  Weaning age _____

  Milestone development _____

  Behavioral/emotional problems _____

  Childhood illness _____

- **Educational History**

  School age begins _____

  Academic performance _____

  Achievements in extracurricular activities _____

  Relationship with teachers and peer group _____

  Termination of study and any other specify _____

- **Play History**

  Likes/dislikes of playmates _____

  Relationship with playmates _____

- **Adolescence**

  _____

  _____

  _____

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- **Puberty**

  Appearance of secondary sexual characteristics _____

  Menarche age _____

  Regularity of cycle and flow _____

  Anxiety related to puberty _____

  Any other abnormalities _____

- **Obstetrical History**

  Number of children _____

  Any abnormalities related to pregnancy/delivery/puerperium _____

  Any termination of pregnancy _____

  Menopause _____

  Any other problems _____

- **Occupational History**

  Age at work start _____

  Type of work _____

  Job satisfaction _____

  Relations with authorities and colleagues _____

- **Marital History**

  Type of marriage _____

  Duration of marriage _____

  Interpersonal relations extramarital relationship if any specify _____

- **Premorbid Personality**

  Type of personality _____

  Family and social relationship _____

  Use of leisure time _____

  Predominant mood _____

  Reaction to stressful events _____

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Attitude towards self and others _____

Religious and moral values _____

Fantasy life _____

Habits _____

Any other specify _____

_____

_____

_____

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Mental Health Nursing I&II
Practical/Clinical Record Book

Salient Features

- **Standardization:** By aligning the assignments with the revised Indian Nursing Council (INC) syllabus of BSc Nursing.
- **Organized documentation:** Moving from loose papers to a structured book format helps in maintaining a clear and organized record of clinical assignments.
- **Educational support:** Providing basic instructions and guidelines within the book assists students in effectively preparing their assignments. This support is invaluable in helping them learn how to document clinical experiences in a professional manner.
- **Comprehensive assessment:** Including an evaluation format for each assignment and an overall clinical evaluation form allows for thorough assessment of students' performance across various areas of psychiatry.
- **Review and evaluation:** The book ensures that students' skills and knowledge are reviewed and evaluated comprehensively.

Manisha Gupta PhD (Nursing), has an impressive academic and professional background in nursing and sociology. Currently, she is Principal, Institute of Nursing, Rabindranath Tagore University; Dean, Faculty of Medical Sciences, Rabindranath Tagore University, Bhopal, Madhya Pradesh, India. She did her BSc (Nursing), Government College of Nursing, Indore, Madhya Pradesh; MA (Sociology), Jiwaji University, Gwalior, Madhya Pradesh; Psychiatric Nursing (MSc Mental Health Nursing), Jabalpur Institute of Nursing Sciences and Research, Jabalpur, Madhya Pradesh; PhD (Nursing), People's University, Bhopal, Madhya Pradesh, India. She is Chairperson of Board of Studies in Nursing in various universities and Women Development Cell, Rabindranath Tagore University, Bhopal, Madhya Pradesh, India.

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