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Clinical Record Book for Mental Health Nursing

For MSc Nursing Students

Name of the Candidate: _____

Name of the Institution: _____

_____

Perkash Kour
Hashim Ismail
Prince Mohamad

JAYPEE

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PART

I

MSc Nursing Ist Year— Student Activities

1. HISTORY TAKING–1

Section	*Details*
1. Identification Data	
Name	
Age	
Sex	
Father/Spouse	
Address	
Education	
Occupation	
Income	
Marital Status	
Religion	
Informant	
Information	Relevant/Not relevant, Adequate/Not adequate
2. Presenting Chief Complaint	(List in patient's and informant's own words with duration in chronological order)
Complaint 1	
Complaint 2	
...	
3. History of Present Illness	
Duration	Days/Weeks/Months/Years
Mode of Onset	Abrupt/Acute/Subacute/Insidious
Course	Continuous/Episodic/Fluctuating/Deteriorating/Improving/Unclear
Intensity	Same/Increasing/Decreasing

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Section	*Details*
Precipitating Factors	Yes/No—If yes, specify
Chronological Description	Abnormal behavior, suicide/homicide, mood, speech, thought content, perception, ADLs, functioning (biological, social, occupational)
4. Treatment History	
Drugs	
ECT	
Psychotherapy	
Family Therapy	
Rehabilitation	
5. Past Psychiatric and Medical History	
Previous Psychiatric Episodes	Number, onset, course
Remission	Complete/Incomplete
Duration of Episodes	
Treatment Details	Side effects, Outcome
Precipitating Factors	If any
Substance Use	Alcohol/Tobacco/Others
Medical History	Surgeries, Accidents, Head injury, Seizures, Unconsciousness, DM, HTN, CAD, STDs, HIV, etc.
6. Family History	
Family Member 1	Age, Education, Occupation, Health, Relation, Age at death (if), Cause of death
Family Member 2	
...	
Genogram	(Draw separately)
7. Personal History	
Perinatal	
Antenatal	Infections, Radiation, Check-ups, Complications
Intranatal	Type of delivery, Complications
Birth	Full-term/Premature/Postmature
Birth Cry	Immediate/Delayed
Birth Defects	Yes/No—If yes, specify
Postnatal Complications	Cyanosis, Convulsions, Jaundice, Infections
Childhood	
Primary Caregiver	
Feeding History	Breastfed/Artificial
Weaning Age	

JAYPEE BROTHERS

Section	*Details*
Milestones	Normal/Delayed
Behavior and Emotions	Thumb-sucking, Tantrums, Nail-biting, Pica, Night terrors, etc.
Childhood Illness	CNS infections, Epilepsy, Neurotic disorders, Malnutrition
Educational History	
Age at School Start	
Academic Performance	
Learning/Attention Disorders	Yes/No
Extracurricular Activities	
Peer/Teacher Relationships	
School Phobia/Conduct Issues	Yes/No
Reason for Leaving School	
Play History	Games played, Stage, With whom; Peer interaction
Adolescent Emotional Problems	Runaway, Smoking, Drugs, Delinquency
Puberty	
Secondary Sexual Traits	Age at appearance
Puberty Anxiety	Yes/No
Menarche	Age, Reaction
Menstrual Cycle	Regularity, Duration, Problems
Obstetric History	
LMP	
Number of Children	
Pregnancy/Delivery Issues	
Abortions/Termination	
Menopause	Age, Symptoms
Occupational History	
Age at First Job	
Job History	Chronological with reasons for change
Current Job Satisfaction	Including work relationships
Suitability to Background	
Sexual and Marital History	
Marriage Type	Arranged/Self-choice
Duration of Marriage	
Spouse and Children	Details (genogram)
Marital/Intimacy Satisfaction	
Extramarital Affairs	If any, specify

JAYPEE BROTHERS

Section	*Details*
Premorbid Personality	
Interpersonal Style	Introvert/Extrovert
Social/Family Relations	
Leisure Time Use	
Predominant Mood	Optimistic/Pessimistic; Stable/Fluctuating
Stress Response	
Attitude Toward Self/Others	
Work and Responsibility Attitude	
Religious/Moral Views	
Fantasy Life	Daydream content and frequency
Habits	
Eating	Regular/Irregular
Elimination	Regular/Irregular
Sleep	Regular/Irregular
Substance Use	Drugs/Tobacco/Alcohol (details)

SIGNATURE OF CLINICAL INSTRUCTOR

JAYPEE BROTHERS

HISTORY TAKING–2

Section	*Details*
1. Identification Data	
Name	
Age	
Sex	
Father/Spouse	
Address	
Education	
Occupation	
Income	
Marital Status	
Religion	
Informant	
Information	Relevant/Not relevant, Adequate/Not adequate
2. Presenting Chief Complaint	(List in patient's and informant's own words with duration in chronological order)
Complaint 1	
Complaint 2	
...	
3. History of Present Illness	
Duration	Days/Weeks/Months/Years
Mode of Onset	Abrupt/Acute/Subacute/Insidious
Course	Continuous/Episodic/Fluctuating/Deteriorating/Improving/Unclear
Intensity	Same/Increasing/Decreasing
Precipitating Factors	Yes/No—If yes, specify
Chronological Description	Abnormal behavior, suicide/homicide, mood, speech, thought content, perception, ADLs, functioning (biological, social, occupational)
4. Treatment History	
Drugs	
ECT	
Psychotherapy	
Family Therapy	
Rehabilitation	
5. Past Psychiatric and Medical History	
Previous Psychiatric Episodes	Number, onset, course
Remission	Complete/Incomplete
Duration of Episodes	
Treatment Details	Side effects, Outcome
Precipitating Factors	If any
Substance Use	Alcohol/Tobacco/Others

JAYPEE BROTHERS

Section	*Details*
Medical History	Surgeries, Accidents, Head injury, Seizures, Unconsciousness, DM, HTN, CAD, STDs, HIV, etc.
6. Family History	
Family Member 1	Age, Education, Occupation, Health, Relation, Age at death (if), Cause of death
Family Member 2	
...	
Genogram	(Draw separately)
7. Personal History	
Perinatal	
Antenatal	Infections, Radiation, Check-ups, Complications
Intranatal	Type of delivery, Complications
Birth	Full-term/Premature/Postmature
Birth Cry	Immediate/Delayed
Birth Defects	Yes/No—If yes, specify
Postnatal Complications	Cyanosis, Convulsions, Jaundice, Infections
Childhood	
Primary Caregiver	
Feeding History	Breastfed/Artificial
Weaning Age	
Milestones	Normal/Delayed
Behavior and Emotions	Thumb-sucking, Tantrums, Nail-biting, Pica, Night terrors, etc.
Childhood Illness	CNS infections, Epilepsy, Neurotic disorders, Malnutrition
Educational History	
Age at School Start	
Academic Performance	
Learning/Attention Disorders	Yes/No
Extracurricular Activities	
Peer/Teacher Relationships	
School Phobia/Conduct Issues	Yes/No
Reason for Leaving School	
Play History	Games played, Stage, With whom; Peer interaction
Adolescent Emotional Problems	Runaway, Smoking, Drugs, Delinquency
Puberty	
Secondary Sexual Traits	Age at appearance
Puberty Anxiety	Yes/No
Menarche	Age, Reaction
Menstrual Cycle	Regularity, Duration, Problems
Obstetric History	
LMP	
Number of Children	

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Section	*Details*
Pregnancy/Delivery Issues	
Abortions/Termination	
Menopause	Age, Symptoms
Occupational History	
Age at First Job	
Job History	Chronological with reasons for change
Current Job Satisfaction	Including work relationships
Suitability to Background	
Sexual and Marital History	
Marriage Type	Arranged/Self-choice
Duration of Marriage	
Spouse and Children	Details (genogram)
Marital/Intimacy Satisfaction	
Extramarital Affairs	If any, specify
Premorbid Personality	
Interpersonal Style	Introvert/Extrovert
Social/Family Relations	
Leisure Time Use	
Predominant Mood	Optimistic/Pessimistic; Stable/Fluctuating
Stress Response	
Attitude Toward Self/Others	
Work and Responsibility Attitude	
Religious/Moral Views	
Fantasy Life	Daydream content and frequency
Habits	
Eating	Regular/Irregular
Elimination	Regular/Irregular
Sleep	Regular/Irregular
Substance Use	Drugs/Tobacco/Alcohol (details)

SIGNATURE OF CLINICAL INSTRUCTOR

JAYPEE BROTHERS

HISTORY TAKING–3

Section	*Details*
1. Identification Data	
Name	
Age	
Sex	
Father/Spouse	
Address	
Education	
Occupation	
Income	
Marital Status	
Religion	
Informant	
Information	Relevant/Not relevant, Adequate/Not adequate
2. Presenting Chief Complaint	(List in patient's and informant's own words with duration in chronological order)
Complaint 1	
Complaint 2	
...	
3. History of Present Illness	
Duration	Days/Weeks/Months/Years
Mode of Onset	Abrupt/Acute/Subacute/Insidious
Course	Continuous/Episodic/Fluctuating/Deteriorating/Improving/Unclear
Intensity	Same/Increasing/Decreasing
Precipitating Factors	Yes/No—If yes, specify
Chronological Description	Abnormal behavior, suicide/homicide, mood, speech, thought content, perception, ADLs, functioning (biological, social, occupational)
4. Treatment History	
Drugs	
ECT	
Psychotherapy	
Family Therapy	
Rehabilitation	
5. Past Psychiatric and Medical History	
Previous Psychiatric Episodes	Number, onset, course
Remission	Complete/Incomplete
Duration of Episodes	
Treatment Details	Side effects, Outcome
Precipitating Factors	If any
Substance Use	Alcohol/Tobacco/Others

JAYPEE BROTHERS

Section	*Details*
Medical History	Surgeries, Accidents, Head injury, Seizures, Unconsciousness, DM, HTN, CAD, STDs, HIV, etc.
6. Family History	
Family Member 1	Age, Education, Occupation, Health, Relation, Age at death (if), Cause of death
Family Member 2	
...	
Genogram	(Draw separately)
7. Personal History	
Perinatal	
Antenatal	Infections, Radiation, Check-ups, Complications
Intranatal	Type of delivery, Complications
Birth	Full-term/Premature/Postmature
Birth Cry	Immediate/Delayed
Birth Defects	Yes/No—If yes, specify
Postnatal Complications	Cyanosis, Convulsions, Jaundice, Infections
Childhood	
Primary Caregiver	
Feeding History	Breastfed/Artificial
Weaning Age	
Milestones	Normal/Delayed
Behavior and Emotions	Thumb-sucking, Tantrums, Nail-biting, Pica, Night terrors, etc.
Childhood Illness	CNS infections, Epilepsy, Neurotic disorders, Malnutrition
Educational History	
Age at School Start	
Academic Performance	
Learning/Attention Disorders	Yes/No
Extracurricular Activities	
Peer/Teacher Relationships	
School Phobia/Conduct Issues	Yes/No
Reason for Leaving School	
Play History	Games played, Stage, With whom; Peer interaction
Adolescent Emotional Problems	Runaway, Smoking, Drugs, Delinquency
Puberty	
Secondary Sexual Traits	Age at appearance
Puberty Anxiety	Yes/No
Menarche	Age, Reaction
Menstrual Cycle	Regularity, Duration, Problems
Obstetric History	
LMP	
Number of Children	
Pregnancy/Delivery Issues	

JAYPEE BROTHERS

Section	*Details*
Abortions/Termination	
Menopause	Age, Symptoms
Occupational History	
Age at First Job	
Job History	Chronological with reasons for change
Current Job Satisfaction	Including work relationships
Suitability to Background	
Sexual and Marital History	
Marriage Type	Arranged/Self-choice
Duration of Marriage	
Spouse and Children	Details (genogram)
Marital/Intimacy Satisfaction	
Extramarital Affairs	If any, specify
Premorbid Personality	
Interpersonal Style	Introvert/Extrovert
Social/Family Relations	
Leisure Time Use	
Predominant Mood	Optimistic/Pessimistic; Stable/Fluctuating
Stress Response	
Attitude Toward Self/Others	
Work and Responsibility Attitude	
Religious/Moral Views	
Fantasy Life	Daydream content and frequency
Habits	
Eating	Regular/Irregular
Elimination	Regular/Irregular
Sleep	Regular/Irregular
Substance Use	Drugs/Tobacco/Alcohol (details)

SIGNATURE OF CLINICAL INSTRUCTOR

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HISTORY TAKING–4

Section	*Details*
1. Identification Data	
Name	
Age	
Sex	
Father/Spouse	
Address	
Education	
Occupation	
Income	
Marital Status	
Religion	
Informant	
Information	Relevant/Not relevant, Adequate/Not adequate
2. Presenting Chief Complaint	(List in patient's and informant's own words with duration in chronological order)
Complaint 1	
Complaint 2	
...	
3. History of Present Illness	
Duration	Days/Weeks/Months/Years
Mode of Onset	Abrupt/Acute/Subacute/Insidious
Course	Continuous/Episodic/Fluctuating/Deteriorating/Improving/Unclear
Intensity	Same/Increasing/Decreasing
Precipitating Factors	Yes/No—If yes, specify
Chronological Description	Abnormal behavior, suicide/homicide, mood, speech, thought content, perception, ADLs, functioning (biological, social, occupational)
4. Treatment History	
Drugs	
ECT	
Psychotherapy	
Family Therapy	
Rehabilitation	
5. Past Psychiatric and Medical History	
Previous Psychiatric Episodes	Number, onset, course
Remission	Complete/Incomplete
Duration of Episodes	
Treatment Details	Side effects, Outcome
Precipitating Factors	If any
Substance Use	Alcohol/Tobacco/Others

JAYPEE BROTHERS

Section	*Details*
Medical History	Surgeries, Accidents, Head injury, Seizures, Unconsciousness, DM, HTN, CAD, STDs, HIV, etc.
6. Family History	
Family Member 1	Age, Education, Occupation, Health, Relation, Age at death (if), Cause of death
Family Member 2	
...	
Genogram	(Draw separately)
7. Personal History	
Perinatal	
Antenatal	Infections, Radiation, Check-ups, Complications
Intranatal	Type of delivery, Complications
Birth	Full-term/Premature/Postmature
Birth Cry	Immediate/Delayed
Birth Defects	Yes/No—If yes, specify
Postnatal Complications	Cyanosis, Convulsions, Jaundice, Infections
Childhood	
Primary Caregiver	
Feeding History	Breastfed/Artificial
Weaning Age	
Milestones	Normal/Delayed
Behavior and Emotions	Thumb-sucking, Tantrums, Nail-biting, Pica, Night terrors, etc.
Childhood Illness	CNS infections, Epilepsy, Neurotic disorders, Malnutrition
Educational History	
Age at School Start	
Academic Performance	
Learning/Attention Disorders	Yes/No
Extracurricular Activities	
Peer/Teacher Relationships	
School Phobia/Conduct Issues	Yes/No
Reason for Leaving School	
Play History	Games played, Stage, With whom; Peer interaction
Adolescent Emotional Problems	Runaway, Smoking, Drugs, Delinquency
Puberty	
Secondary Sexual Traits	Age at appearance
Puberty Anxiety	Yes/No
Menarche	Age, Reaction
Menstrual Cycle	Regularity, Duration, Problems
Obstetric History	
LMP	
Number of Children	
Pregnancy/Delivery Issues	

JAYPEE BROTHERS

Section	*Details*
Abortions/Termination	
Menopause	Age, Symptoms
Occupational History	
Age at First Job	
Job History	Chronological with reasons for change
Current Job Satisfaction	Including work relationships
Suitability to Background	
Sexual and Marital History	
Marriage Type	Arranged/Self-choice
Duration of Marriage	
Spouse and Children	Details (genogram)
Marital/Intimacy Satisfaction	
Extramarital Affairs	If any, specify
Premorbid Personality	
Interpersonal Style	Introvert/Extrovert
Social/Family Relations	
Leisure Time Use	
Predominant Mood	Optimistic/Pessimistic; Stable/Fluctuating
Stress Response	
Attitude Toward Self/Others	
Work and Responsibility Attitude	
Religious/Moral Views	
Fantasy Life	Daydream content and frequency
Habits	
Eating	Regular/Irregular
Elimination	Regular/Irregular
Sleep	Regular/Irregular
Substance Use	Drugs/Tobacco/Alcohol (details)

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HISTORY TAKING–5

Section	*Details*
1. Identification Data	
Name	
Age	
Sex	
Father/Spouse	
Address	
Education	
Occupation	
Income	
Marital Status	
Religion	
Informant	
Information	Relevant/Not relevant, Adequate/Not adequate
2. Presenting Chief Complaint	(List in patient's and informant's own words with duration in chronological order)
Complaint 1	
Complaint 2	
...	
3. History of Present Illness	
Duration	Days/Weeks/Months/Years
Mode of Onset	Abrupt/Acute/Subacute/Insidious
Course	Continuous/Episodic/Fluctuating/Deteriorating/Improving/Unclear
Intensity	Same/Increasing/Decreasing
Precipitating Factors	Yes/No—If yes, specify
Chronological Description	Abnormal behavior, suicide/homicide, mood, speech, thought content, perception, ADLs, functioning (biological, social, occupational)
4. Treatment History	
Drugs	
ECT	
Psychotherapy	
Family Therapy	
Rehabilitation	
5. Past Psychiatric and Medical History	
Previous Psychiatric Episodes	Number, onset, course
Remission	Complete/Incomplete
Duration of Episodes	
Treatment Details	Side effects, Outcome
Precipitating Factors	If any
Substance Use	Alcohol/Tobacco/Others

JAYPEE BROTHERS

Section	*Details*
Medical History	Surgeries, Accidents, Head injury, Seizures, Unconsciousness, DM, HTN, CAD, STDs, HIV, etc.
6. Family History	
Family Member 1	Age, Education, Occupation, Health, Relation, Age at death (if), Cause of death
Family Member 2	
...	
Genogram	(Draw separately)
7. Personal History	
Perinatal	
Antenatal	Infections, Radiation, Check-ups, Complications
Intranatal	Type of delivery, Complications
Birth	Full-term/Premature/Postmature
Birth Cry	Immediate/Delayed
Birth Defects	Yes/No—If yes, specify
Postnatal Complications	Cyanosis, Convulsions, Jaundice, Infections
Childhood	
Primary Caregiver	
Feeding History	Breastfed/Artificial
Weaning Age	
Milestones	Normal/Delayed
Behavior and Emotions	Thumb-sucking, Tantrums, Nail-biting, Pica, Night terrors, etc.
Childhood Illness	CNS infections, Epilepsy, Neurotic disorders, Malnutrition
Educational History	
Age at School Start	
Academic Performance	
Learning/Attention Disorders	Yes/No
Extracurricular Activities	
Peer/Teacher Relationships	
School Phobia/Conduct Issues	Yes/No
Reason for Leaving School	
Play History	Games played, Stage, With whom; Peer interaction
Adolescent Emotional Problems	Runaway, Smoking, Drugs, Delinquency
Puberty	
Secondary Sexual Traits	Age at appearance
Puberty Anxiety	Yes/No
Menarche	Age, Reaction
Menstrual Cycle	Regularity, Duration, Problems
Obstetric History	
LMP	
Number of Children	
Pregnancy/Delivery Issues	

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Section	*Details*
Abortions/Termination	
Menopause	Age, Symptoms
Occupational History	
Age at First Job	
Job History	Chronological with reasons for change
Current Job Satisfaction	Including work relationships
Suitability to Background	
Sexual and Marital History	
Marriage Type	Arranged/Self-choice
Duration of Marriage	
Spouse and Children	Details (genogram)
Marital/Intimacy Satisfaction	
Extramarital Affairs	If any, specify
Premorbid Personality	
Interpersonal Style	Introvert/Extrovert
Social/Family Relations	
Leisure Time Use	
Predominant Mood	Optimistic/Pessimistic; Stable/Fluctuating
Stress Response	
Attitude Toward Self/Others	
Work and Responsibility Attitude	
Religious/Moral Views	
Fantasy Life	Daydream content and frequency
Habits	
Eating	Regular/Irregular
Elimination	Regular/Irregular
Sleep	Regular/Irregular
Substance Use	Drugs/Tobacco/Alcohol (details)

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2. MENTAL STATUS EXAMINATION–1

MENTAL STATUS EXAMINATION (MSE) TABLE

1. General appearance and behavior	***Findings***
Appearance	
Facial expression	
Level of grooming	
Level of cleanliness	
Level of consciousness	
Mode of entry	
Behavior	
Co-operativeness	
Eye-to-eye contact	
Psychomotor activity	
Rapport	
Gesturing	
Posturing	
Other movements	
Other catatonic phenomena	
Conversion/dissociative signs	
Compulsive acts or rituals	
Hallucinatory behavior	
2. Speech	***Findings***
Initiation	
Reaction time	
Rate	
Productivity	
Volume	
Tone	
Relevance	
Stream	
Coherence	
Others (e.g., neologism)	
Sample of speech	
3. Mood and affect	***Findings***
Subjective mood	
Objective affect	
Predominant mood state	
Congruence with thought/situation	

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4. Thought	***Findings***
Stream (flow)	
Form (structure)	
Delusions (specify type and example)	
Ideas (e.g., guilt, helplessness)	
Thought alienation phenomena	
Obsessions/compulsions	
Phobias	
Preoccupations	
5. Perception	***Findings***
Illusions	
Hallucinations (type and example)	
Somatic passivity	
Déjà vu/Jamais vu	
Depersonalization/Derealization	
6. Cognitive function	***Findings***
Consciousness	
Orientation	
– Time	
– Place	
– Person	
Attention (Digit span forward/backward)	
Concentration (100–7, 40–3, months backward)	
Memory	
– Immediate	
– Recent	
– Verbal recall	
– Remote: personal/impersonal/illness-related	
Intelligence	
– General knowledge	
– Arithmetic ability	
Abstraction	
– Proverb interpretation	
– Similarities/dissimilarities	
Judgment	
– Personal	
– Social	
– Test judgment	
7. Insight	***Rating (1–6)***
Level of Insight	

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8. Diagnostic formulation	
Summary of MSE findings, working diagnosis, relevant factors	

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MENTAL STATUS EXAMINATION–2

MENTAL STATUS EXAMINATION (MSE) TABLE

1. General appearance and behavior	***Findings***
Appearance	
Facial expression	
Level of grooming	
Level of cleanliness	
Level of consciousness	
Mode of entry	
Behavior	
Co-operativeness	
Eye-to-eye contact	
Psychomotor activity	
Rapport	
Gesturing	
Posturing	
Other movements	
Other catatonic phenomena	
Conversion/dissociative signs	
Compulsive acts or rituals	
Hallucinatory behavior	
2. Speech	***Findings***
Initiation	
Reaction time	
Rate	
Productivity	
Volume	
Tone	
Relevance	
Stream	
Coherence	
Others (e.g., neologism)	
Sample of speech	
3. Mood and affect	***Findings***
Subjective mood	
Objective affect	
Predominant mood state	
Congruence with thought/situation	

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4. Thought	***Findings***
Stream (flow)	
Form (structure)	
Delusions (specify type and example)	
Ideas (e.g., guilt, helplessness)	
Thought alienation phenomena	
Obsessions/compulsions	
Phobias	
Preoccupations	
5. Perception	***Findings***
Illusions	
Hallucinations (type and example)	
Somatic passivity	
Déjà vu/Jamais vu	
Depersonalization/Derealization	
6. Cognitive function	***Findings***
Consciousness	
Orientation	
– Time	
– Place	
– Person	
Attention (Digit span forward/backward)	
Concentration (100–7, 40–3, months backward)	
Memory	
– Immediate	
– Recent	
– Verbal recall	
– Remote: personal/impersonal/illness-related	
Intelligence	
– General knowledge	
– Arithmetic ability	
Abstraction	
– Proverb interpretation	
– Similarities/dissimilarities	
Judgment	
– Personal	
– Social	
– Test judgment	
7. Insight	***Rating (1–6)***
Level of Insight	

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8. Diagnostic formulation	
Summary of MSE findings, working diagnosis, relevant factors	

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For MSc Nursing Students

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Perkash Kour is a Professor-cum-Principal with distinguished qualifications including an MA, PGDHom, and MSc in Psychiatry. With years of dedicated service in nursing education and mental health, she has been a guiding force in shaping the careers of countless nursing professionals. Her expertise lies in curriculum development, psychiatric nursing, and fostering a holistic approach to patient care.

Hashim Ismail is an Assistant Professor holding an MSc in Psychiatry. He is deeply passionate about clinical teaching and is known for his ability to simplify complex psychiatric concepts for students. His areas of interest include psychopathology, therapeutic communication, and evidence-based nursing interventions.

Prince Mohamad is an Assistant Professor with an MSc in Psychiatry. Committed to excellence in mental health nursing education, he focuses on integrating practical skills with theoretical knowledge. His work emphasizes the importance of clinical reasoning, patient's assessment, and modern therapeutic modalities in patient recovery.

Together, the authors bring a wealth of academic knowledge and clinical experience, ensuring that this record book is both authoritative and immensely practical for students.

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