



PRACTICE CASE / ID

DATE

SETTING

The history is the patient's story; the exam is the mental status exam; safety comes first.

WHAT MATTERS MOST

- Patient's own words for mood and symptoms
- Suicidal and homicidal ideation: plan, intent, means
- Substance use
- Full mental status exam in Objective

OFTEN MISSED

- Protective factors in the risk assessment
- Collateral history
- Access to firearms or other means

S SUBJECTIVE

Chief complaint In the patient's words.

HPI Symptoms, duration, stressors, sleep, appetite, energy, concentration, function.

Safety Suicidal/homicidal ideation, plan, intent, means, prior attempts.

Psychiatric history Diagnoses, hospitalizations, medications tried.

Substance use

Social Supports, housing, work, legal, access to weapons.

Collateral Name the source.

O OBJECTIVE

Vital signs

Mental status exam Appearance, behavior, speech, mood (patient's words), affect, thought process, thought content, perception, cognition, insight, judgment.

Screening scores With the tool named.

A ASSESSMENT

Diagnosis With supporting criteria.

Risk assessment Risk factors, protective factors, overall level.

P PLAN

Safety plan

Medications Changes and monitoring.

Therapy / referrals

Follow-up Interval; crisis resources given.
