

CASE STUDY FORMAT

IDENTIFYING DATA AND GENERAL DISCRPTION

Name, sex, age, race, culture, relationship status, appearance and referral source (how did the individual present for treatment).

CHIEF COMPLAINT/ HISTORY OF PRESENT ILLNESS:

Chief complaint, significant signs and symptoms of illness (*provide as much subjective data as possible. Use quotes when possible.*). Include stressors, precipitating factors, mood, lethality, any psychotic symptoms, nutritional status, changes in appetite, sleep and activity disturbance, ability to care for basic personal needs, spending habits and ability to maintain employment, energy level (scale 1-5), changes in libido or sexual pattern, changes in concentration.

Medications that are presently prescribed and treatment prior to admission.

Past and present compliance with medication and treatment program.

PAST PSYCHIATRIC HISTORY:

History of illness: First onset of illness and description. Previous psychiatric diagnosis.

Treatment History: number of hospitalizations, other treatment alternative, what medications have worked in the past, what hasn't. Any barriers to treatment. Any previous history of suicide or homicide attempts, describe.

FAMILY PSYCHIATRIC HISTORY:

Any family history of mental health issues, treatment. Specific history of suicide attempts.

ALCOHOL/ SUBSTANCE USE & TREATMENT HISTORY:

List type of substance used, onset of use, amount used, how often.

Longest length of abstinence.

Treatment history, compliance.

FAMILY HISTORY OF ALCOHOL/ SUBSTANCE USE:

PAST MEDICAL HISTORY:

Any medical diagnoses, past or present. Any medical complaints. LMP, history of STDs.

Lab Results: List abnormal or significant lab results and diagnostic studies/ procedures, and interpretation of findings. (Cite references used.)

SURGICAL HISTORY:

Any surgical history.

ALLERGIES:

Allergies to medications (give specific reaction)

Allergies to food or environmental stimulants.

Height _____ Weight _____

BP _____ P _____ R _____

SOCIAL/ CULTURAL/ RELIGIOUS HISTORY:

Significant friendships

Hobbies, Activities, Interests.

Cultural Practices

Values- what does the individual value most in life?

Belief Pattern- does the individual describe him/herself as a spiritual person?

Do these practices provide the individual comfort?

FAMILY/DEVELOPMENTAL HISTORY:

Individual's developmental history. Parental involvement, birth order. Living relatives and status of relationships. Traumatic events as a child (e.g. divorce, death of a caregiver, emotional, physical, or sexual abuse, etc)

Educational History

PERSONAL HISTORY:

Individual's role-relationship pattern. Present relationship status, describe. Any children, describe relationship. Who does individual rely on for support?

Occupation and current and past employment history. Current living arrangements, with whom?

Individual's perception of self-esteem (1-5 scale)

Erikson's Developmental Stage

Stress Rating Scale (1-5), identification of stressors. Individual's coping mechanisms, defense mechanisms. (use one example and describe how it is used by client)/strengths and limitations/ is the client receptive to alternative coping strategies?

Any other significant information individual has shared.

MENTAL STATUS EXAMINATION

Exam	Upon Admission	Current
Attitude toward interviewer		
Appearance		
Flow of thought/ speech pattern		
Abstract thinking		
Concentration		
Orientation		
Memory		
Danger to self or others		
Mood		
Affect		
Thought content and process		
Hallucinations		
Delusions		
Insight		
Judgment		

DIAGNOSTIC IMPRESSION:

Axis I:

Axis II:

Axis III:

Axis IV:

Axis V:

PRIORITY NURSING DIAGNOSES & GOALS: (Using the Master Problem List)

Give at least **six** priority nursing diagnoses with **two** NOC indicators for each diagnosis.

TREATMENT PLAN:

Describe treatment plan on inpatient unit, including activities, teaching, medications, and any other therapy. Describe client's receptiveness in participation with plan of care.

TEACHING AND DISCHARGE PLAN:

Identify discharge teaching needs (include medication teaching, support groups, outpatient follow-up):

Anticipated discharge plan: List specific plan. Where will the client be discharged to? What type of treatment follow-up is planned? What are the anticipated home care needs?

MEDICATION WHICH CLIENT IS RECEIVING:

(Use one page for each medication. Cite references.)

Generic name:

Brand name:

Major action:

Therapeutic dose range:

Route of administration:

Dose/ Route of administration for this client (if prn – how often is client receiving?)

Reason client is receiving this medication:

Common side effects:

Major adverse effects:

Adverse/Side effects manifested in this client:

Pertinent nursing responsibilities in caring for clients who are on this drug:

STUDENT REFLECTION UPON WRITING A CASE STUDY:

What did you learn about your client that impacted you?

How did you change as a result of this experience?

TEXTBOOK DESCRIPTION OF DISEASE PROCESS	CLIENTS PRESENTATION OF DISEASE PROCESS
Diagnosis	
Etiology/Psychopathology	
Clinical Signs and Symptoms/Clinical Manifestations	
Medical and Nursing Management	

Reference:

Worksheet for Case Study

(Optional)

Student _____

Date _____

Client _____

Identifying Data and General Description

Sex	Race
Culture	Relationship Status
Appearance	
Referral Source	

Chief Complaint/ HX of Present Illness

Chief Complaint
Signs/ Symptoms of Illness (provide quotes if possible)
Stressors
Precipitating Factors
Mood
Lethality
Psychotic Symptoms
Nutritional Status
Changes in Appetite
Sleep and Activity Disturbances
Ability to Do ADL's
Spending Habits
Ability to Maintain Employment
Energy Level (Scale 1-5)
Changes in Sexual Pattern
Changes in Concentration
Compliance with Meds and Treatment

Past Psychiatric Hx

Hx of Illness
Onset of Illness and Description
Previous Psychiatric diagnosis
of Hospitalizations
Other Treatment Alternatives
Other Meds that have worked in the past
Meds that have not worked in the past
Barriers to Treatment
Hx of Suicide or Homicide Attempts (describe)

Family Hx

Family Hx of Mental History
Treatments Used
Fam Hx of Suicide

Alcohol/ Substance Abuse

Type Used
Onset/ Amount/ Frequency
Longest Length of Abstinence
Treatment Hx/ Compliance
Family Hx of Alcohol/ Substance Abuse

Medical Hx

Medical Diagnosis
Medical Complaints
LMP
Hx of STD
Labs (abnormal and significant findings, diagnostic studies/ interpretations of findings)

Medical HX *continued*

Surgical Hx
Allergies (food/ meds)

Social/ Cultural/ Religious Hx

Significant Friendships
Hobbies/ Activities/ Interest
Cultural Practices
Values (most in life)
Belief Pattern (spiritual person?)
Spiritual Practices provide comfort?

Family. Developmental Hx

Individual Hx
Parental Involvement
Birth Order
Living Relatives (status of relationship)
Traumatic Events in childhood (divorce, death of caregiver, emotional, physical, sexual abuse, etc.)
Educational Hx

Personal Hx

Individual role relationship pattern
Present Relationship Status (describe)
Children? (describe relationship)
Who do they rely on for support?
Occupational Hx (past and present)
Current living arrangements
Perception of Self Esteem (scale 1-5)
Ercikson's developmental stage
Stress rating (scale 1-5)
Identification of stressors

Personal Hx *continued*

Coping mechanisms
Defense mechanisms
Strengths/ Weaknesses
Receptive to alternative coping strategies
Other significant info Patient shared

Mental Status Exam upon admission

Attitude toward interviewer
Appearance
Flow of thought/ speech pattern
Abstract thinking
Concentration
Orientation
Memory
Danger to self/ others
Mood
Affect
Thought content and process
Hallucinations
Delusions
Insight
Judgment

Current Mental Status Exam

Attitude toward interviewer
Appearance
Flow of thought/ speech pattern
Abstract thinking
Concentration
Orientation
Memory
Danger to self/ others
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