BROWN INTERVIEW CHECKLIST

Facilitator initials ______ Interviewer ____________________________ Observer ____________________________ Date ____________

For skills on a continuum, faculty may choose to give points anywhere on that continuum, and designate the appropriate score for that skill.

I. FLOW OF THE INTERVIEW

A) Opening

1) Prepares oneself for interview; puts aside other obligations; focuses attention on pt

2) Greets patient - i.e. Hello, Good Afternoon, etc.
   a) Verbal greeting
   b) Shakes hands

3) Introduces self, and role on the health care team.

4) IF APPROPRIATE: Attends to patient's comfort - physical position comfortable, noise and visual distractions minimized.

5) IF APPROPRIATE: Minimizes distractions.

6) IF APPROPRIATE: Asks the patient his/her understanding of the nature of the interview (i.e., teaching exercise, referral, etc.).

7) Calibration - Assesses the patient's ability to communicate.

8) Invitation to speak - Starts with an open question or statement. (e.g., How can I help you? What problems brought you to the hospital?)

9) Allows patient to finish opening statement without interruption

B) Exploration of Problems (Information Gathering)

1) Survey - ascertains all major symptoms, concerns, and goals for visit (more appropriate for outpatient visit).

2) IF APPROPRIATE: Negotiates priorities for problems to be discussed.

3) Asks patient to tell the story of the illness from the beginning until now.

4) Focuses using open-to-closed cone: starts w/open question, then "tell me more"/"what else" until all symptoms elicited; ends w/specific questions.

5) IF APPROPRIATE: Clarifies patient's unclear statements.

6) IF APPROPRIATE: Interrupts to redirect.

7) Avoids asking more than one question at a time.

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OVER
(Exploration of Problems, Information Gathering, cont.)

8) Segment Summary - Restates the content and/or feeling about an area of the patient's concern and checks accuracy.

9) Transition - Acknowledges the transition from one area to another.

C) Closing

1) Asks patient if he/she has any questions or comments.  YES ___  NO ___

2) States appreciation for the patient's efforts in the interview.  YES ___  NO ___

3) Shakes hands.  YES ___  NO ___

4) IF APPROPRIATE: Makes appropriate follow-up arrangements.  YES ___  NO ___  NA

II. INTERPERSONAL SKILLS

A) Facilitation Skills

1) Eye contact - Appropriate length to enhance patient comfort.  YES ___  NO ___

2) Open posture - Arms uncrossed, facing the patient.  F..................P..................DN

3) Head nod, "mm-hm," repeats the patient's last statement, etc.  F..................P..................DN

4) Uses silences to facilitate the patient's expression of thoughts and feelings.  YES ___  NO ___

B) Relationship Skills (Conveying Empathy)

1) Reflection - Restates the patient's expressed emotion or inquires about emotions.  F..................P..................DN

2) Legitimation - Expresses understandability of the patient's emotions.  YES ___  NO ___

3) Respect - Expresses respect for the patient's coping efforts or makes a statement of praise.  YES ___  NO ___

4) IF APPROPRIATE: Support - Expresses willingness to be helpful to the patient in addressing his/her concerns.  YES ___  NO ___  NA

5) IF APPROPRIATE: Partnership - Expresses willingness to work together with the patient.  YES ___  NO ___  NA
III. PATIENT RESPONSES
1) Patient appears engaged in the interview.

2) Patient appears comforted and relaxed.

3) Patient freely discusses his/her concerns.

Comments:

IV. KEY CONTENT AREAS (check if discussed)

A) History of the Present Illness/Dimensions of Symptoms

1. Characteristics of symptoms
   __ a) Onset
   __ b) Location
   __ c) Radiation
   __ d) Quality
   __ e) Severity (on a 0 – 10 scale)
   __ f) Duration
   __ g) Frequency
   __ h) Modifying factors
   __ i) Associated signs & symptoms
   __ j) Past experience(s) with symptoms

2. Context: What was the psychosocial context of the onset of the symptoms?

3. Psychosocial consequences: how have the symptoms affected the patient’s life?

B) Understanding the Patient’s Perspective

1. Meaning of the illness: patient's ideas and concerns about causes ___,
   diagnosis __, and implications ___ of the illness?

2. Main concerns – what are the patient's biggest worries?

C) Past Medical History

1. Medical
2. Surgical
3. OB/GYN
4. Psychiatric
5. Problems with drugs or alcohol
6. Injuries
7. Health Maintenance
   __ Periodic Health Examinations
   __ Immunizations
   __ Injury Prevention (seat belts, texting/cell phone use while driving, etc.)
8. __ Allergies
9. __ Medications (including OTC, vitamins, herbals)

D) Family History

1. Illnesses in family members/deaths: dates and age at death
   __ Parents __ Siblings __ Children
   Ask if illnesses like diabetes, HT, heart disease, or cancer run in the family.

E) Psychosocial and Behavioral History

1. Living arrangements
   __ With whom does the patient live?
   __ How are things at home?

2. Support/secondary gains:
   __ Are there people the patient can rely on for help?
   __ How have family or friends responded to the illness?

3. Significant other?
   __ How is that going?

4. Work/Daily activities?
   __ Satisfaction?
   __ Occupational risks (chemical, physical, emotional)

5. Exercise: specific physical activity, frequency, and duration?

6. Diet?

7. Substance use: current? past?
   Tobacco ___ ___
   Alcohol ___ ___
   Illicit drugs ___ ___

8. Financial concerns?

9. Stress?
10. Significant life events: deaths, divorces, etc.?
11. Mood?
    __ Anxiety?
    __ Depression?

12. Sexual history/function:
    __ Currently sexually active?
    __ Sexual orientation?
    __ Risk assessment?
    __ Sexual problems or concerns?

13. Ever any physical or sexual abuse?

F) Functional Status (If Appropriate)

Does the patient’s health status interfere with:

1. Taking care of him/herself (e.g. toileting, bathing, dressing)
2. Daily activities (e.g. working, shopping, house cleaning, cooking)?

V. GENERAL COMMENTS: Use back of this page if needed.