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

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

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<thead>
<tr>
<th>C) Closing</th>
<th>FULLY EMPLOYS</th>
<th>PARTIALLY EMPLOYS</th>
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<tr>
<td></td>
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<td>8) Segment Summary - Restates the content and/or feeling about an area of the patient's concern and checks accuracy.</td>
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<td>9) Transition - Acknowledges the transition from one area to another.</td>
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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, herbls)

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?

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.