There is cause for encouragement; a rainbow has made its appearance on the horizon. Of the approximately three thousand advisory letters written each year by the Industrial Health Division of the National Safety Council, 20 per cent refer to physical examinations; 60 per cent embrace chemical health hazards; the remainder refer to miscellaneous subjects. We have an increasing number of calls for health educational and informational material, and for suggestions for the carrying out of health courses and campaigns in industry. An increasingly larger number of questions are coming to us on the sociological problems of industrial health. A large industrial association has prepared a manual on health and first aid for distribution to its members.

We also have requests for actual statistical data showing the beneficial results accruing from employment physical examinations, periodic reëxaminations, the correction of physical defects, and the like. Such figures are obtainable only in rare instances and I do not need to further impress upon you the difficulty of showing tangible returns. The keeping and analysis of records is time-consuming and expensive, but such data must be provided if we are to establish the economic necessity for medical and safety services.

The administration of industrial medical programs shows all the permutations and combinations that are possible on a Chinese lottery ticket. Industrial relations groups claim that they are responsible for the administration of industrial medical and safety services; safety departments feel that medical and health procedures belong under their jurisdiction; it is comparatively rare, but has occurred, that a physician has undertaken the management of all three activities. Probably the ideal arrangement is to place all three departments on an equal authoritative basis and make them all directly responsible to the general manager. I can see no large measure of success for any unless all three activities are constructively coördinated.

Economists tell us that within the next five years efficiency will be increasingly emphasized and in meeting greater competition the industry which is most efficient will make the most progress. Certainly there is a direct relationship between health and efficiency, and I would interpret this to mean that more emphasis will be placed on health.

END TO BE ACHIEVED

Finally, I think that we can feel that this young man—industrial medicine—has a real chance for making a name for himself and building a character and reputation worthy of the consideration of other medical specialties. We envision, not an industrial world where employees live by health rules and become veritable hygienic robots—God forbid—but workshops, market places, and stores where employees will be given the opportunity to achieve the birthright of every useful citizen—a sane mind in a sound body.

NEUROPSYCHIATRIC CASE RECORDS*

A SUGGESTED OUTLINE

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THE following outline of neuropsychiatric examination is an effort to outline the minimal essential facts to be ascertained in the neurologic and psychiatric examination of a patient. Such a scheme, in the main, is at present utilized in the respective dispensaries of the Johns Hopkins Hospital, where the author was a one-time staff member.

Inasmuch as the time the student and clinician can usually give to each patient is all too meager, it is very important that the physician utilize a systematic mode of approach which at least gives attention to the minimal essential facts and is also time-saving and sound in content and method. Such a history must be selective, but also plastic enough to permit elaboration on important meaningful facts, especially if they can perhaps be used therapeutically, or at least light be thrown on the modus operandi of the psychobiological reaction.

Source and Reliability of the History.—Since patients often cannot give the history in logical sequence, it is often best to first take pencil notes and later record such in ink when they have been reviewed and corrected by the clinician in charge. In most cases it is not only unsatisfactory, but a waste of time to examine a patient who comes alone to the clinic. Every effort must be bent to obtain first the history from a relative, friend, or social welfare worker who may have at hand the pertinent facts of the case. It is an invariable rule that the informant should be interviewed first before attempting to examine the patient. Strict privacy should be maintained by proper separate cubical or examining-room facilities.

Neatness is desirable. Make headings for special topics, and underline important facts.

Complaint: Give a succinct, concrete statement of what the patient (in his own words) or others referring the patient would like help for, and the duration of each complaint.

Onset of Present Illness: Earliest changes and developments noticed by friends or experienced by patient, and their evolution. Situation; with special attention to facts involving difficulty of adaptation.

Personal History: Make the chronology definite. Born where, and when? Illnesses in infancy, childhood, adult life.

School.—Opportunities and results; give dates.

Positions held; efficiency; satisfaction in work.

Habits in regard to use of alcohol, tobacco, etc., and sexual indulgence.

Marriage and *children,* etc. Give dates.

In some cases we need detail of *personal development* and of *formation of habits.*

Personality: Thinks in terms of I (egotropic), or in terms of we (koinotropic); disposition; ability to get along with others, etc.

* From the State Education Department of the University of the State of New York.

Note any difficult situations, especially any failures of adaptation and the reaction of such failures.

FAMILY HISTORY: Take with special reference to occurrence of insanity, nervousness, alcoholism, etc., in grandparents, parents, siblings, collaterals. Detail obligatory where positive facts are available. Chart family tree with usual symbols.

MENTAL STATUS:

1. *General Behavior:* (As observed by the physician.)

2. *Stream of Activity and Talk:* Note special characteristics, such as incoherence, flight of ideas, distractability. Give brief verbatim example to illustrate.

3. *Mood and Special Preoccupations:* Begin with a general question, such as: How do you feel? If necessary, make the question more specific, for example: Sad? Afraid?

Imaginations and Delusions: Any trouble recently? Peculiar experiences? (Have you been troubled by imaginations?) Been fairly treated? Persecuted? Under any special influence, for example, hypnotism, electricity, etc.?

Hallucinations: Do you hear voices? Do you see things? What, where, and when?

Obsessions and Compulsions.

4. *Sensorium and Intellectual Resources:*

Orientation: (As to places and dates and persons.)

Memory: (Specially important in organic psychoses.)

(*a*) *Remote past* (life with dates controlled in taking history).

(*b*) Recent past (some account of past twenty-four hours).

(*c*) Retention of memory tests (number, name, objects shown).

Grasp of General Information: (Presidents? Mayor? Wars? etc.)

Calculation.

Judgment: Ability to make reasonable plans, to give due value to practical considerations.

Insight into Sickness: Any admission of being sick or nervous? Realization of the nature of the disorder?

Speech and Writing Tests.

Intelligence (superior, average, borderline or subnormal).

PHYSICAL AND NEUROLOGICAL STATUS: * With particular attention to neurological status. Always note general *physical habitus* (asthenic or linear, pyknic or lateral, athletic or dysplastic type), nutritional status, condition of teeth, tonsils and nasopharyngeal patency; thyroid gland and any general glandular enlargement; pulse rate, blood pressure, temperature; also urinalysis, blood chemistry, lumbar puncture, x-ray, electrical reactions as indicated. A blood Wassermann test should be made routinely.

Dr. Frank Ford's negative neurologic form will assist in bringing to the front the minimal neurologic facts to be investigated:

Cranial Nerves: II—Pupils equal, central and circular; reaction to light and accommodation; vision subjectively good or poor; any gross defects in visual fields; are fundi negative. III, IV, VI—Negative. V—Negative. VII—Negative. VIII—Negative. IX, X, XI—Negative. XII—Negative.

Motor: No weakness, atrophy or fibrillations, grips equal, gait normal, no tremor or ataxia, muscle tone good, speech normal, no loss of sphincter control.

Sensory: No loss of deep or superficial sensibility made out. No astereognosis, no loss of sense of position or vibratory sense, no tenderness of spine, muscles or nerves, no pain or hyperesthesia.

Reflexes: Tendon reflexes all active and equal, no clonus, no Hoffman, abdominals active, plantars flexor.

SUMMARY: Briefly summarize (1) the most telling facts in the history and (2) the positive psychiatric and neurologic findings, grouping them so as to indicate their significance.

IMPRESSION: The formulation of reaction type, symptom complexes, tentative diagnosis, and other diagnoses to be considered.

WORK SHEET: Make a note of further topics and examinations to be investigated in subsequent interviews, laboratory examinations, social service facts, etc.

TREATMENT

Abnormal Children—Case Histories

A brief outline is here indicated for use in history taking in abnormal children.

FAMILY HISTORY: Is here specially important.

PERSONAL HISTORY: In the development special attention to:

1. *Neurotic traits* (night terrors, disturbed sleep, dreams, bed-wetting, "St. Vitus dance," stammering, capriciousness with regard to food, control of sphincters, attacks, etc.).

2. *Traits of Character* (difficulty of training, obstinacy, suggestibility; affection, cruelty; outbursts of temper; seclusiveness; cleanliness and orderliness; general adaptability; school record; special interests.

3. *Environmental influences* (rôle of father and mother, spoiling or severity, frankness or repression; sleeping arrangements, dietetic regimen, influence of comrades.)

MENTAL STATUS: When the child is below the school grade corresponding to age, test intelligence by Binet-Simon scale.

COMMENT

The above outlines of neuropsychiatric examination should be conceived as mere scaffolds on which are to be hung and elaborated further significant facts of examinations and investigations. They must be utilized in the perspective of one's trained and critical common sense, according to the best judgment of the examining physician, of the opportunities available, and of the needs of the patient.

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* Whenever time permits, it is highly desirable that the psychiatrist make the physical examination of the person whom he is to diagnose and treat. Here is rich opportunity to observe patient-physician reactions, many of which may be significant in understanding the patient's personality and temperamental and emotional problems.