

Bear, there isn't one most reliable source for every clinical question. Each captures something different: the patient's experience, a consistent measurement, or the clinician's interpretation. AI can help organise those sources, but its summary is another interpretation to check.

Source	Strongest use	Main limitation
Patient recorded interview, summarised by AI	Preserves the patient's own account, chronology, context, and unexpected concerns. The recording can be revisited when a detail matters.	Speech recognition and summarisation can mishear a drug name, miss a negation, omit a detail, or make an inference sound like something the patient said.
Patient check boxes or validated scales	Consistent questions and scores make screening and change over time easier to compare, especially for symptoms such as depression or pain.	The choices can miss nuance. A score depends on how the patient understands the question and is generally a screen or measure , not a diagnosis.
Physician interview and note	Best for probing inconsistencies, examining the patient, weighing other evidence, assessing risk, and formulating a clinical judgement.	The note is selective: time pressure, recall, and clinical assumptions can leave out symptoms the patient considers important.

The distinction is **reliability versus completeness**. A validated questionnaire is often the most *consistent* way to track a defined symptom. The original recording is the most *checkable* record of what was said, provided the audio is clear. A physician's assessment is the most useful for a *clinical decision* when it integrates the interview, examination, scales, history, and other evidence. None should automatically overrule the others. Research comparing patient and clinician symptom reports has found that patients may report symptoms earlier or differently than clinicians record them.

My recommended workflow: collect a short validated questionnaire, record an open interview where appropriate, have AI draft a summary with links or timestamps to the source audio, then have the clinician confirm important facts and document their own assessment. Keep **"patient reported," "scale result," "clinician observed,"** and **"clinical inference"** visibly distinct. Review medication names, negations, timing, risk statements, and any AI-generated diagnosis particularly carefully. In one 2026 study, most AI-generated notes had no significant errors, but the authors still identified significant errors in some notes—enough to warrant review before signing.

For psychiatry, I'd give the **patient's account priority for subjective experience**, use scales to track change, and use the **clinician's direct assessment for diagnosis and safety decisions**. A disagreement between the three is useful information to investigate, rather than a reason to pick a winner.

[Practice Name] Pre-Visit Intake Form

This form is used to help your clinician prepare before your first visit. It is completely check-box based and asks for no names or contact information.

Mark each box clearly with an X • check all that apply • do NOT write your name or any identifying details on this form.

Office use only - Form ID _____

Age range:

- ☐ Under 18 ☐ 18–25 ☐ 26–40 ☐ 41–55 ☐ 56–70 ☐ Over 70

Sex:

- ☐ Female ☐ Male ☐ Prefer not to say.

1. What brings you in today?

Check the main reasons (all that apply)

- | | | |
|---|--|--|
| ☐ Anxiety / constant worry | ☐ Depression / low mood | ☐ Trouble sleeping |
| ☐ Panic attacks | ☐ Mood swings | ☐ Irritability / anger |
| ☐ Trouble focusing / attention | ☐ Trauma-related symptoms | ☐ Memory / thinking problems |
| ☐ Grief / loss | ☐ Relationship difficulties | ☐ Alcohol / drug use |
| ☐ Medication review | ☐ Second opinion | ☐ Other (will discuss at visit) |

In the past 2 weeks I have had (check all that apply):

Mood

- | | | |
|---|---|---|
| ☐ Sad or empty most of the day | ☐ Loss of interest or pleasure | ☐ Feelings of hopelessness |
| ☐ Guilt or feeling worthless | ☐ Low energy / fatigue | ☐ Change in appetite or weight |

Anxiety

- | | | |
|--|--|---|
| ☐ Excessive worry | ☐ Feeling restless or on edge | ☐ Panic attacks |
| ☐ Avoiding situations out of fear | ☐ Racing heart / physical tension | ☐ Repetitive thoughts or rituals |

Energy and thinking

- | | | |
|--|--|--|
| ☐ Unusually high energy | ☐ Little need for sleep | ☐ Racing thoughts |
| ☐ Impulsive spending or risk-taking | ☐ Trouble concentrating | ☐ Feeling suspicious or watched |
| ☐ Hearing or seeing things others don't | ☐ Memory lapses | ☐ Anger outbursts |

Trauma and other

- | | | |
|---|--|---|
| ☐ Flashbacks or nightmares | ☐ Always on-guard / easily startled | ☐ Feeling numb or detached |
| ☐ Binge eating or restricting food | ☐ Cravings for alcohol or drugs | ☐ None of these |

2. When did this start, and how has it changed?

It began:

- | | | |
|--|--|--|
| ☐ Less than 1 month ago | ☐ 1–6 months ago | ☐ 6–12 months ago |
| ☐ 1–5 years ago | ☐ More than 5 years ago | ☐ Since childhood / teens |

Since then it has been:

- | | | | |
|---|---|--|---|
| ☐ Getting better | ☐ About the same | ☐ Getting worse | ☐ Comes and goes |
|---|---|--|---|

Effect on daily life (work, home, relationships):

- ☐ None ☐ Mild ☐ Moderate ☐ Severe

It began around (check all that apply):

- ☐ Loss / bereavement ☐ Job or financial stress ☐ Relationship change
☐ Medical illness or injury ☐ Trauma ☐ Medication or substance change
☐ No clear trigger ☐ Not sure ☐ Other (will discuss at visit)

3. Past mental health history

- ☐ I have never received mental health treatment

Prior treatments (check all that apply):

- ☐ Therapy / counseling ☐ Psychiatric medication ☐ Substance use treatment
☐ TMS / ECT / ketamine ☐ Support group ☐ Other (will discuss at visit)

Psychiatric hospitalizations:

- ☐ None ☐ 1 ☐ 2-3 ☐ 4 or more

Family history (check all that apply):

- ☐ Depression ☐ Bipolar disorder ☐ Schizophrenia / psychosis ☐ Anxiety
☐ Substance use ☐ Suicide ☐ None known ☐ Not sure

4. Current medications and medical conditions

Medical conditions (check all that apply):

- ☐ None ☐ High blood pressure ☐ Diabetes
☐ Heart disease ☐ Thyroid problem ☐ Seizures / epilepsy
☐ Head injury / concussion ☐ Chronic pain ☐ Sleep apnea
☐ Liver or kidney disease ☐ Cancer ☐ Other (will discuss at visit)

Allergies to medications:

- ☐ No known drug allergies ☐ Yes (will discuss at visit)

Current medications (check all that apply):

- ☐ None ☐ Antidepressant ☐ Anti-anxiety / benzodiazepine
☐ Mood stabilizer ☐ Antipsychotic ☐ Stimulant (ADHD)
☐ Sleep medication ☐ Pain medication / opioid ☐ Blood pressure medication
☐ Diabetes medication ☐ Thyroid medication ☐ Supplements / herbal
☐ Other (will discuss at visit) ☐ Not sure

5. Life right now

Work:

- ☐ Full-time ☐ Part-time ☐ Not working
☐ Student ☐ Retired ☐ On leave / disability

Relationship status:

- ☐ Single ☐ Married / partnered ☐ Separated / divorced ☐ Widowed

Current stress level:

☐ Low ☐ Moderate ☐ High ☐ Severe

Sleep — hours per night:

☐ Less than 4 ☐ 4–6 ☐ 6–8 ☐ More than 8

Sleep problems (check all that apply):

☐ Trouble falling asleep ☐ Waking during the night ☐ Waking too early
☐ Sleeping too much ☐ Nightmares ☐ No sleep problems

Substance use:

	None	Occasional	Weekly	Daily
Alcohol	☐	☐	☐	☐
Tobacco / nicotine	☐	☐	☐	☐
Cannabis	☐	☐	☐	☐
Other drugs (non-prescribed)	☐	☐	☐	☐

6. What are you hoping to get out of treatment?

Check all that apply.

☐ Feel less anxious ☐ Improve my mood ☐ Sleep better
☐ Better focus / attention ☐ Medication evaluation or adjustment ☐ Learn coping skills / therapy
☐ Understand what is going on ☐ Second opinion ☐ Improve work / school functioning
☐ Improve my relationships ☐ Manage stress ☐ Other (will discuss at visit)

7. Prior records

Records from prior clinicians and hospitals help your clinician prepare. Please send them to the office separately — do not attach them to this form.

☐ Prior psychiatrist / prescriber ☐ Therapist / counselor ☐ Hospital / ER
☐ Primary care ☐ Lab or imaging results ☐ Psychological testing
☐ I have no prior records

8. Safety**Thoughts of harming yourself or ending your life:**

☐ Never ☐ In the past, not now ☐ Yes, currently

Thoughts of harming someone else:

☐ No ☐ Yes

If you are in immediate danger or crisis, call 911 or 988 (Suicide & Crisis Lifeline) now. Do not wait for your appointment.

☐ I understand my responses will be reviewed by my clinician before my visit, with the assistance of AI-based analysis.

Subject: Working definition of AI in psychiatry

Date: Sunday, September 6, 2026 at 7:34:33 AM Eastern Daylight Time

From: Bob Pollack

A working definition of **Artificial Intelligence (AI) in psychiatry** centers on the use of computational techniques and data-driven algorithms to augment—rather than replace—clinical decision-making, pattern recognition, and the delivery of mental health care.

Rather than a standalone automated therapist, AI in psychiatry functions primarily as an advanced cognitive and analytical support tool.

Core Dimensions of the Working Definition

- **Clinical Decision Support (CDS):** Computational tools (such as machine learning and natural language processing) designed to analyze complex psychiatric data—including electronic health records, clinician notes, vocal patterns, text logs, and neuroimaging. These systems flag risk markers, assist in diagnostic clarification, and track symptom trajectories over time.
- **Predictive Analytics & Stratification:** Algorithms trained to identify statistical correlations in historical patient data to estimate probabilities of future clinical events, such as treatment resistance, adverse drug reactions, relapse risks, or non-adherence.
- **Augmentation Over Substitution:** A framework emphasizing that AI models provide supplementary insights, data organization, and workflow efficiencies (e.g., documentation assistance), leaving final diagnosis, formulation, and treatment ownership strictly to the human clinician.
- **Digital Phenotyping Integration:** The continuous, passive collection of behavioral and physiological data (via smartphone sensors or wearable technology) to monitor daily activity, sleep routines, and social interaction markers that may signal early clinical deterioration or recovery milestones.

Key Boundaries and Constraints

To remain clinically and ethically sound, a working definition must recognize critical operational boundaries:

1. **Augmentation, Not Replacement:** AI cannot replicate the emotional resonance, intuition, or deep empathy inherent in the therapeutic alliance.
2. **Mitigation of Bias:** Systems are bound by the historical datasets they are trained on; active governance is required to prevent algorithmic biases that could lead to diagnostic disparities among marginalized populations.
3. **Transparency:** Employs "explainable AI" principles so clinicians can understand the underlying clinical signals or statistical weights driving a specific algorithmic recommendation.