

Nursing 201 – Nursing Care of Special Populations Mental Status Examination

1. Personal Information

- a. Age
- b. Gender
- c. Marital status
- d. Religious preference
- e. Race & ethnicity
- f. Employment
- g. Living arrangements

2. Appearance

- a. Grooming and dress
- b. Level of hygiene
- c. Pupil dilation or constriction
- d. Facial expression
- e. Height, weight, nutritional status, presence of body piercings, tattoos, scars
- f. Relationship between appearance and age

3. Behavior

- a. Excessive or reduced body movements
- b. Peculiar body movements (scanning the environment, repetitive gestures, balance, gait)
- c. Abnormal movements (tardive dyskinesia (p. 279), tremors)
- d. Level of eye contact

4. Speech

- a. Rate: slow, rapid, normal
- b. Volume: loud, soft, normal
- c. Disturbances (articulation problems, slurring, stuttering, mumbling)

5. Mood

- a. Affect (flat, bland, animated, angry, withdrawn, appropriate)
- b. Mood (sad, labile, euphoric)

6. Disorders of the Form of Thought (p. 261-264)

- a. Thought process (disorganized, coherent, flight of ideas, neologisms, thought blocking, circumstantiality)
- b. Thought content (delusions, obsessions)

7. Perceptual Disturbances (p. 264)

- a. Hallucinations (auditory, visual, tactile, olfactory, gustatory)
- b. Illusions

8. Cognition

- a. Orientation (time, place, person)
- b. Level of consciousness (alert, confused, clouded, unconscious, comatose)
- c. Memory (remote, recent, immediate)
- d. Attention (serial 7s- count back from 100 by 7s)
- e. Abstraction (can they identify proverbs correctly)
- f. Insight (degree of awareness of illness, behaviors, problems, and their cause)
- g. Judgment (soundness of problem solving and decisions)

9. Ideas of harming Self or Others (p. 380)

- a. Suicidal or homicidal history and current thoughts
- b. Presence of a plan
- c. Means to carry out the plan