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 arraignments

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    a. Affect (flat, bland, animated, angry, withdrawn, appropriate)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