

# Mood Disorder Questionnaire (MDQ)

Name: Victoria Pacilla Date: 4/22/25

Instructions: Check (✓) the answer that best applies to you. Please answer each question as best you can.

	Yes	No
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	<input checked="" type="radio"/>	<input type="radio"/>
...you were so irritable that you shouted at people or started fights or arguments?	<input checked="" type="radio"/>	<input type="radio"/>
...you felt much more self-confident than usual?	<input type="radio"/>	<input checked="" type="radio"/>
...you got much less sleep than usual and found you didn't really miss it?	<input type="radio"/>	<input checked="" type="radio"/>
...you were much more talkative or spoke faster than usual?	<input checked="" type="radio"/>	<input type="radio"/>
...thoughts raced through your head or you couldn't slow your mind down?	<input checked="" type="radio"/>	<input type="radio"/>
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	<input checked="" type="radio"/>	<input type="radio"/>
...you had much more energy than usual?	<input type="radio"/>	<input checked="" type="radio"/>
...you were much more active or did many more things than usual?	<input type="radio"/>	<input checked="" type="radio"/>
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	<input type="radio"/>	<input checked="" type="radio"/>
...you were much more interested in sex than usual?	<input type="radio"/>	<input checked="" type="radio"/>
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	<input checked="" type="radio"/>	<input type="radio"/>
...spending money got you or your family in trouble?	<input type="radio"/>	<input checked="" type="radio"/>
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time? <i>Please check 1 response only.</i>	<input checked="" type="radio"/>	<input type="radio"/>
3. How much of a problem did any of these cause you — like being able to work; having family, money, or legal troubles; getting into arguments or fights? <i>Please check 1 response only.</i>		
	<input type="radio"/> No problem	<input type="radio"/> Minor problem
	<input type="radio"/> Moderate problem	<input checked="" type="radio"/> Serious problem
4. Have any of your blood relatives (ie, children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	<input checked="" type="radio"/>	<input type="radio"/>
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	<input checked="" type="radio"/>	<input type="radio"/>

This questionnaire should be used as a starting point. It is not a substitute for a full medical evaluation. Bipolar disorder is a complex illness, and an accurate, thorough diagnosis can only be made through a personal evaluation by your doctor.

# NURSING SHIFT ASSESSMENT

DATE: 4/22/25



SHIFT:  Day(7A-7P)  Night(7P-7A)

Label	
Name: _____	
MR#: _____	D.O.B. _____

<b>Orientation</b> <input checked="" type="checkbox"/> Person <input checked="" type="checkbox"/> Place <input checked="" type="checkbox"/> Time <input checked="" type="checkbox"/> Situation	<b>Affect</b> <input checked="" type="checkbox"/> Appropriate <input type="checkbox"/> Inappropriate <input type="checkbox"/> Flat <input type="checkbox"/> Guarded <input checked="" type="checkbox"/> Improved <input checked="" type="checkbox"/> Blunted	<b>ADL</b> <input checked="" type="checkbox"/> Independent <input type="checkbox"/> Assist <input type="checkbox"/> Partial Assist <input type="checkbox"/> Total Assist	<b>Motor Activity</b> <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Psychomotor retardation <input type="checkbox"/> Psychomotor agitation <input type="checkbox"/> Posturing <input type="checkbox"/> Repetitive acts <input type="checkbox"/> Pacing	<b>Mood</b> <input type="checkbox"/> Irritable <input type="checkbox"/> Depressed <input type="checkbox"/> Anxious <input type="checkbox"/> Dysphoric <input type="checkbox"/> Agitated <input type="checkbox"/> Labile <input type="checkbox"/> Euphoric	<b>Behavior</b> <input type="checkbox"/> Withdrawn <input type="checkbox"/> Suspicious <input checked="" type="checkbox"/> Tearful <input type="checkbox"/> Paranoid <input type="checkbox"/> Isolative <input type="checkbox"/> Preoccupied <input type="checkbox"/> Demanding <input type="checkbox"/> Aggressive <input type="checkbox"/> Manipulative <input type="checkbox"/> Complacent <input type="checkbox"/> Sexually acting out <input type="checkbox"/> Cooperative <input type="checkbox"/> Guarded <input type="checkbox"/> Intrusive
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**Thought Processes**  
 Goal Directed  Tangential  Blocking  
 Flight of Ideas  Loose association  Indecisive  
 Illogical  Delusions: (type) \_\_\_\_\_

**Thought Content**  
 Obsessions  Compulsions  Suicidal thoughts  
 Hallucinations:  Auditory  Visual  Olfactory  Tactile  Gustatory  
 Worthless  Somatic  Assaultive Ideas  Logical  
 Hopeless  Helpless  Homicidal thoughts

**Pain:** Yes No Pain scale score 0 Locations back  
 Is pain causing any physical impairment in functioning today  No  if yes explain sciatica

**Nursing Interventions:**

<input type="checkbox"/> Close Obs. q15	<input type="checkbox"/> Ind. Support	<input type="checkbox"/> Reality Orientation	<input type="checkbox"/> Toilet Q2 w/awake	<input type="checkbox"/> 1 to 1 Observation _____ reason (specify)
<input checked="" type="checkbox"/> Milieu Therapy	<input type="checkbox"/> Monitor Intake	<input checked="" type="checkbox"/> Encourage Disclosure	<input type="checkbox"/> Neuro Checks	<input checked="" type="checkbox"/> Rounds Q2
<input checked="" type="checkbox"/> V/S <input type="checkbox"/> O2 sat.	<input checked="" type="checkbox"/> Tx Team	<input checked="" type="checkbox"/> Wt. Monitoring	<input type="checkbox"/> Elevate HOB	<input type="checkbox"/> MD notified _____
<input checked="" type="checkbox"/> Nursing group/session (list topic): _____				
<input type="checkbox"/> ADLs assist	<input checked="" type="checkbox"/> I&O	<input type="checkbox"/> PRN Med per order _____		

Ask Question 2*	Since Last Contact	
	YES	NO
2) <u>Have you actually had thoughts about killing yourself?</u>	LOW	
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6		
3) <u>Have you been thinking about how you might do this?</u>	MOD	✓
4) <u>Have you had these thoughts and had some intention of acting on them?</u> E.g., "I thought about taking an overdose, but I never made a specific plan as to when where or how I would actually do it...and I would never go through with it."	HIGH	✓
5) <u>Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?</u> As opposed to "I have the thoughts, but I definitely will not do anything about them."	HIGH	✓
6) <u>Have you done anything, started to do anything, or prepared to do anything to end your life?</u>	HIGH	✓

Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.

Low Risk  Moderate Risk  High Risk

**REVIEW OF SYSTEMS**

**Cardio/Pulmonary:**  
 WNL  Elevated B/P  B/P  
 Chest Pain  
 Edema:  upper  lower

**Respiratory/Breath sounds:**  
 Clear  Rales  Crackles  Wheezing  
 Cough  S.O.B  Other: \_\_\_\_\_  
 O2 @ \_\_\_\_\_ l/min  Cont.  PRN  
 Via  nasal cannula  face mask

**Neurological / L.O.C.:**  
 Unimpaired  Lethargic  Sedated  
 Dizziness  Headache  Seizures  
 Tremors  Other: \_\_\_\_\_

**Musculoskeletal/Safety:**  
 Ambulatory  MAE  Full ROM  
 Walker  W/C  Immobile  
 Pressure ulcer  Unsteady gait  
 Risk for pressure ulcer  
 Reddened area(s)

**Nutrition/Fluid:**  
 Adequate  Inadequate  Dehydrated  
 Supplement  Prompting  Other \_\_\_\_\_  
 new onset of choking risks assessed

**Skin:**  
 Bruises  Tear  No new skin issues  
 Wound(s) (see Wound Care Packet)  
 Abrasion  Integumentary Assess  
 Other: \_\_\_\_\_

**Elimination:**  
 Continent  Incontinent  Catheter  
 Diarrhea  OTHER \_\_\_\_\_

Hours of Sleep: \_\_\_\_\_  Day  Night

At Risk for Falls:  Yes  No

**At Risk for FALL Precautions:**  
 Arm Band  Nonskid footwear  
 BR light  ambulate with assist  
 Call bell  Clear path  
 Edu to call for assist  Bed alarm  
 Chair alarm  1:1 observation level  
 Assist with ADLs  Geri Chair  
 Ensure assistive devices near  
 Other \_\_\_\_\_

Nurse Signatures) [Signature] Date: 4/22/25 Time: 8:30

Student Name: Victoria Padilla

Date: 4/22/25

IM6 (Acute Psychiatric) Critical Thinking Worksheet

<p><b>1. DSM-5 Diagnosis and Brief Pathophysiology (include reference):</b> Anxiety</p>	<p><b>2. Psychosocial Stressors (i.e. Legal, Environmental, Relational, Developmental, Educational, Substance Use, etc.):</b> Boyfriend</p>	<p><b>3. DSM-5 Criteria for Diagnosis (Asterisk or Highlight Symptoms Your Patient Exhibits and Include References)</b> Excessive anxiety and worry.  Sleep disturbance Restlessness Difficulty concentrating</p>
<p><b>4. Medical Diagnoses:</b> N/A</p>		
<p><b>5. Diagnostic Tests Pertinent or Confirming of Diagnosis</b> Further medical assessment needed</p>	<p><b>6. Lab Values That May Be Affected:</b> N/A</p>	<p><b>7. Current Treatment:</b> milieu therapy TX team I/O encourage disclosure wt. monitoring Rounds Q2</p>

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<p><b>8. Focused Nursing Diagnosis:</b></p> <p>Anxiety (Panic)</p>	<p><b>12. Nursing Interventions related to the Nursing Diagnosis in #7:</b></p> <ol style="list-style-type: none"><li>1. Reassure client of her safety and security.</li></ol>	<p><b>13. Patient Teaching:</b></p> <ol style="list-style-type: none"><li>1. Identify potential triggers and patterns to better manage or avoid them.</li></ol>
<p><b>9. Related to (r/t):</b></p> <p>Situational and maturational crises</p>	<p><b>Evidenced Based Practice:</b> may fear for her life.</p> <ol style="list-style-type: none"><li>2. Keep surrounding low in stimuli</li></ol>	<ol style="list-style-type: none"><li>2. Promote a regular diet, sleep, and exercise.</li></ol>
<p><b>10. As evidenced by (aeb):</b></p> <p><del>Restless</del> Restless, Nausea.</p>	<p><b>Evidenced Based Practice:</b> stimulating environment may increase level of anxiety</p> <ol style="list-style-type: none"><li>3. Use simple words, speak calmly and clearly.</li></ol>	<p><b>14. Discharge Planning/Community Resources:</b></p> <ol style="list-style-type: none"><li>1. Follow-up appointments with therapist, PCP, mental health professional.</li></ol>
<p><b>11. Desired patient outcome:</b></p> <p>maintain calm, non-threatening manner.</p>	<p><b>Evidenced Based Practice:</b> client is unable to comprehend anything</p>	<ol style="list-style-type: none"><li>3. Encourage involvement of supportive family and friends in the recovery process.</li></ol>