

## Mental Status Exam

Client Name <u>Sovi</u>	Date <u>1/27/23</u>
<b>OBSERVATIONS</b>	
Appearance	<input checked="" type="checkbox"/> Neat <input type="checkbox"/> Disheveled <input type="checkbox"/> Inappropriate <input type="checkbox"/> Bizarre <input type="checkbox"/> Other
Speech	<input checked="" type="checkbox"/> Normal <input type="checkbox"/> Tangential <input type="checkbox"/> Pressured <input type="checkbox"/> Impoverished <input type="checkbox"/> Other
Eye Contact	<input checked="" type="checkbox"/> Normal <input type="checkbox"/> Intense <input type="checkbox"/> Avoidant <input type="checkbox"/> Other
Motor Activity	<input checked="" type="checkbox"/> Normal <input type="checkbox"/> Restless <input type="checkbox"/> Tics <input type="checkbox"/> Slowed <input type="checkbox"/> Other
Affect	<input checked="" type="checkbox"/> Full <input type="checkbox"/> Constricted <input type="checkbox"/> Flat <input type="checkbox"/> Labile <input type="checkbox"/> Other
Comments:	
<b>MOOD</b>	
<input type="checkbox"/> Euthymic <input type="checkbox"/> Anxious <input type="checkbox"/> Angry <input type="checkbox"/> Depressed <input type="checkbox"/> Euphoric <input type="checkbox"/> Irritable <input checked="" type="checkbox"/> Other	
Comments: <u>Good mood</u>	
<b>COGNITION</b>	
Orientation Impairment	<input checked="" type="checkbox"/> None <input type="checkbox"/> Place <input type="checkbox"/> Object <input type="checkbox"/> Person <input type="checkbox"/> Time
Memory Impairment	<input checked="" type="checkbox"/> None <input type="checkbox"/> Short-Term <input type="checkbox"/> Long-Term <input type="checkbox"/> Other
Attention	<input checked="" type="checkbox"/> Normal <input type="checkbox"/> Distracted <input type="checkbox"/> Other
Comments:	
<b>PERCEPTION</b>	
Hallucinations	<input checked="" type="checkbox"/> None <input type="checkbox"/> Auditory <input type="checkbox"/> Visual <input type="checkbox"/> Other
Other	<input checked="" type="checkbox"/> None <input type="checkbox"/> Derealization <input type="checkbox"/> Depersonalization
Comments:	
<b>THOUGHTS</b>	
Suicidality	<input checked="" type="checkbox"/> None <input type="checkbox"/> Ideation <input type="checkbox"/> Plan <input type="checkbox"/> Intent <input type="checkbox"/> Self-Harm
Homicidality	<input checked="" type="checkbox"/> None <del>Aggressive</del> <input type="checkbox"/> Intent <input type="checkbox"/> Plan
Delusions	<input type="checkbox"/> None <input type="checkbox"/> Grandiose <input checked="" type="checkbox"/> Paranoid <input type="checkbox"/> Religious <input type="checkbox"/> Other
Comments:	
<b>BEHAVIOR</b>	
<input checked="" type="checkbox"/> Cooperative <input type="checkbox"/> Guarded <input type="checkbox"/> Hyperactive <input type="checkbox"/> Agitated <input type="checkbox"/> Paranoid	
<input type="checkbox"/> Stereotyped <input type="checkbox"/> Aggressive <input type="checkbox"/> Bizarre <input type="checkbox"/> Withdrawn <input type="checkbox"/> Other	
Comments:	
<b>INSIGHT</b>	<input checked="" type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor    Comments:
<b>JUDGMENT</b>	<input checked="" type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor    Comments:

## PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?  
(Use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + 1 + 2 + 3  
=Total Score: 7

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult  
at all

Somewhat  
difficult

Very  
difficult

Extremely  
difficult