

Kassy M.  
1/27/23  
#1

### Mental Status Exam

Client Name		Kawia H.	
Date		01/27/2023	
<b>OBSERVATIONS</b>			
Appearance	<input checked="" type="checkbox"/> Neat	<input checked="" type="checkbox"/> Dishveled	<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"/> Avoiant <input type="checkbox"/> Other	
Motor Activity	<input type="checkbox"/> Normal	<input type="checkbox"/> Restless <input type="checkbox"/> Tics <input checked="" 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 checked="" type="checkbox"/> Euthymic <input checked="" type="checkbox"/> Anxious <input type="checkbox"/> Angry <input type="checkbox"/> Depressed <input type="checkbox"/> Euphoric <input type="checkbox"/> Irritable <input type="checkbox"/> Other			
Comments: eager for conversation			
<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: ARO x4			
<b>PERCEPTION</b>			
Hallucinations	<input type="checkbox"/> None	<input checked="" type="checkbox"/> Auditory <input type="checkbox"/> Visual <input type="checkbox"/> Other	
Other	<input type="checkbox"/> None	<input checked="" type="checkbox"/> Derealization <input checked="" type="checkbox"/> Depersonalization	
Comments: use to hear things/voices, but not recently			
<b>THOUGHTS</b>			
Suicidality	<input type="checkbox"/> None	<input checked="" type="checkbox"/> Ideation <input checked="" type="checkbox"/> Plan <input type="checkbox"/> Intent <input checked="" type="checkbox"/> Self-Harm	
Homicidality	<input type="checkbox"/> None	<input type="checkbox"/> Aggressive <input type="checkbox"/> Intent <input checked="" type="checkbox"/> Plan	
Delusions	<input checked="" type="checkbox"/> None	<input type="checkbox"/> Grandiose <input type="checkbox"/> Paranoid <input type="checkbox"/> Religious <input type="checkbox"/> Other	
Comments: Had plans, but not in the last two days			
<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 checked="" 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 <input type="checkbox"/> Comments:	
<b>JUDGMENT</b>		<input checked="" type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Comments:	

