

Mental Status Exam

Client Name <i>Denise</i>	Date <i>1-24-23</i>
OBSERVATIONS	
Appearance	<input type="checkbox"/> Neat <i>Shiny</i> <input checked="" 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:	
MOOD	
<input type="checkbox"/> Euthymic <input checked="" type="checkbox"/> Anxious <input type="checkbox"/> Angry <input type="checkbox"/> Depressed <input type="checkbox"/> Euphoric <input checked="" type="checkbox"/> Irritable <input type="checkbox"/> Other	
Comments:	
COGNITION	
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 type="checkbox"/> Normal <input type="checkbox"/> Distracted <input checked="" type="checkbox"/> Other <i>to start only on ADHD so attention was off; then gone</i>
Comments:	
PERCEPTION	
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:	
THOUGHTS	
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 checked="" type="checkbox"/> None <input type="checkbox"/> Aggressive <input type="checkbox"/> Intent <input 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:	
BEHAVIOR	
<input checked="" type="checkbox"/> Cooperative <input type="checkbox"/> Guarded <input checked="" type="checkbox"/> Hyperactive <input checked="" type="checkbox"/> Agitated <input type="checkbox"/> Paranoid	
<input type="checkbox"/> Stereotyped <input checked="" type="checkbox"/> Aggressive <input type="checkbox"/> Bizarre <input type="checkbox"/> Withdrawn <input type="checkbox"/> Other	
Comments:	
INSIGHT	<input type="checkbox"/> Good <input checked="" type="checkbox"/> Fair <input type="checkbox"/> Poor Comments:
JUDGMENT	<input type="checkbox"/> Good <input checked="" type="checkbox"/> Fair <input type="checkbox"/> Poor Comments: