# Mental Status Exam

| Client Name | Andria | Date | 1/27/2023 |
|---|---|---|---|

## OBSERVATIONS

| | | | | | |
|---|---|---|---|---|---|
| Appearance | ☒ Neat | ☐ Disheveled | ☐ Inappropriate | ☐ Bizarre | ☐ Other |
| Speech | ☒ Normal | ☐ Tangential | ☐ Pressured | ☐ Impoverished | ☐ Other |
| Eye Contact | ☒ Normal | ☐ Intense | ☐ Avoidant | ☐ Other | |
| Motor Activity | ☒ Normal | ☐ Restless | ☐ Tics | ☐ Slowed | ☐ Other |
| Affect | ☒ Full | ☐ Constricted | ☐ Flat | ☐ Labile | ☐ Other |
| Comments: | | | | | |

## MOOD

| | | | | | | |
|---|---|---|---|---|---|---|
| ☐ Euthymic | ☐ Anxious | ☐ Angry | ☐ Depressed | ☐ Euphoric | ☐ Irritable | ☒ Other |
| Comments: | Content | | | | | |

## COGNITION

| | | | | | |
|---|---|---|---|---|---|
| Orientation Impairment | ☒ None | ☐ Place | ☐ Object | ☐ Person | ☐ Time |
| Memory Impairment | ☒ None | ☐ Short-Term | ☐ Long-Term | ☐ Other | |
| Attention | ☒ Normal | ☐ Distracted | ☐ Other | | |
| Comments: | | | | | |

## PERCEPTION

| | | | | |
|---|---|---|---|---|
| Hallucinations | ☒ None | ☐ Auditory | ☐ Visual | ☐ Other |
| Other | ☒ None | ☐ Derealization | ☐ Depersonalization | |
| Comments: | | | | |

## THOUGHTS

| | | | | | |
|---|---|---|---|---|---|
| Suicidality | ☐ None | ☒ Ideation | ☐ Plan | ☐ Intent | ☐ Self-Harm |
| Homicidality | ☒ None | ☐ Aggressive | ☐ Intent | ☐ Plan | |
| Delusions | ☒ None | ☐ Grandiose | ☐ Paranoid | ☐ Religious | ☐ Other |
| Comments: | | | | | |

## BEHAVIOR

| | | | | |
|---|---|---|---|---|
| ☒ Cooperative | ☐ Guarded | ☐ Hyperactive | ☐ Agitated | ☐ Paranoid |
| ☐ Stereotyped | ☐ Aggressive | ☐ Bizarre | ☐ Withdrawn | ☐ Other |
| Comments: | | | | |

| | | | | |
|---|---|---|---|---|
| **INSIGHT** | ☒ Good | ☐ Fair | ☐ Poor | Comments: |
| **JUDGMENT** | ☐ Good | ☒ Fair | ☐ Poor | Comments: |

NIMH TOOLKIT

# asQ Suicide Risk Screening Tool

Ask Suicide-Screening Questions

## Ask the patient:

1. **In the past few weeks, have you wished you were dead?** ☒ Yes ○ No
2. **In the past few weeks, have you felt that you or your family would be better off if you were dead?** ☒ Yes ○ No
3. **In the past week, have you been having thoughts about killing yourself?** ☒ Yes ○ No
4. **Have you ever tried to kill yourself?** ○ Yes ○ No

   If yes, how? (3) OD ~~& [illegible]~~ | All three suicidal attempts from a drug overdose (OD)
   ↓ Drug

   When? ~~First 2020, 2021~~ May ~~Augu 2022~~
   First attempt 2020, Second in May 2021, and third August 2022

*If the patient answers* **Yes** *to any of the above, ask the following acuity question:*

5. **Are you having thoughts of killing yourself right now?** ○ Yes ☒ No

   If yes, please describe: _____

## Next steps:

- If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (**Note: Clinical judgment can always override a negative screen*).
- **If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity:**
  - ☐ "Yes" to question #5 = **acute positive screen** (imminent risk identified)
    - **Patient requires a STAT safety/full mental health evaluation.** Patient cannot leave until evaluated for safety.
    - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.
  - ☒ **"No"** to question #5 = **non-acute positive screen** (potential risk identified)
    - **Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed.** Patient cannot leave until evaluated for safety.
    - Alert physician or clinician responsible for patient's care.

## Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text "HOME" to 741-741