Mental Status Exam

Client Name	A.R.	Date	2/3/2023

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 fidgety
Affect	☒ Full	☐ Constricted	☐ Flat	☐ Labile	☐ Other

Comments:

MOOD

☐ Euthymic ☐ Anxious ☐ Angry ☒ Depressed ☐ Euphoric ☐ Irritable ☐ Other

Comments: "I don't want to be here, I just know I need the help".

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☐ Stereotyped	☐ Aggressive	☐ Bizarre	☐ Withdrawn	☐ Other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? 2018- overdosed on 128 pills of clonidine
   2016 - self harm w/ razor blade - arm + thigh.

   When? Twice. 2018. 2016.

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