

Mental Status Exam

Client Name <u>Sky</u>	Date <u>2-17-2023</u>
OBSERVATIONS	
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:	
MOOD	
<input type="checkbox"/> Euthymic <input checked="" type="checkbox"/> Anxious <input type="checkbox"/> Angry <input type="checkbox"/> Depressed <input checked="" type="checkbox"/> Euphoric <input type="checkbox"/> Irritable <input type="checkbox"/> Other	
Comments: <u>Tired, happy, sad a mix of feeling</u>	
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 checked="" type="checkbox"/> Normal <input type="checkbox"/> Distracted <input type="checkbox"/> Other
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 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 <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 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:	
INSIGHT	<input checked="" type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor Comments:
JUDGMENT	<input checked="" type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor Comments:

Reflection Assignment

Noticing	Interpreting	Responding	Reflecting
<p>What did you notice during your mental status examination of the client? Were there any assessments that were abnormal or that stood out to you? <u>THE PT WAS WILLING TO ANSWER ALL QUESTIONS I HAD FOR HER. SHE WAS A LITTLE SAD BECAUSE SHE IS READY TO GO HOME. SHE WAS COOPERATIVE AND SAID THAT SHE APPRECIATE ME ASKING HER ABOUT HER DAY.</u></p>	<p>If something stood out to you or it was abnormal, explain it's potential cause or patterns that you noticed. Describe any similar situations you have experienced / as well as the similarities or differences between the experiences. Is your interpretation of the situation links to pathophysiology at all, if so - briefly explain. <u>THE ONLY THING THAT STOOD OUT WAS SHE STATED SHE WAS FEELING TIRED, SAD, A LITTLE HAPPY SO MIXED EMOTIONS, SHE STATED SHE WANTED TO GO HOME BUT HAPPY SHE'S HAVING A GOOD DAY. I'VE EXPERIENCED THIS WHEN PEOPLE ARE</u></p>	<p>What additional assessment information do you need based upon your interpretation? What can you do as a nursing student? What did you do? What could you do as a nurse? What therapeutic communication techniques did you utilize? <u>AS A NURSING STUDENT I CAN MORE BE SURE TO UNDERSTAND THE PT THOUGHT PROCESS AND SEE WHAT I CAN DO TO ASSIST HER IN MAKING THINGS BETTER. AS A NURSE I CAN ASSESS THE PROBLEMS & FIND COPING MEASURES TO ASSIST HER FIND A HEALTHY</u></p>	<p>What is something that you learned? What is something that you might do differently in the future? What is something that you did well? What additional knowledge or skills do you need to help you with future situations like this. Describe any changes in your values or feelings based on this interaction. <u>I HEARRED THAT SHE GENUINELY WANTS HELP & SHE DOESN'T WANT TO HAVE THOSE THOUGHTS. I WILL CONTINUE TO BE COMPASSIONATE & FIND WAYS THAT BENEFICIAL TO THE PT. I HEARD TO LET HER TALK AND I JUST LISTEN. I MADE HER FEEL COMFORTABLE</u></p>
<p><u>JUST NORMALLY HAVING A GOOD OR BAD DAY MIXED EMOTIONS THAT REGULAR</u></p>	<p><u>JUST NORMALLY HAVING A GOOD OR BAD DAY MIXED EMOTIONS THAT REGULAR</u></p>	<p><u>THAT CAN ASSIST WITH DEPRESSION OR THE MENTAL BACKGROUND</u></p>	<p><u>THAT CAN ASSIST WITH DEPRESSION OR THE MENTAL BACKGROUND</u></p>

Noticing	Interpreting	Responding	Reflecting
<p>Why did you choose this additional assessment? What did you notice during your additional assessment of the client? Were there any assessments that were abnormal or that stood out to you? THE PT WAS HERE FOR SUICIDE RISK SO I CHOSE THAT ONE TO FIND OUT WHY I noticed that she didn't have a plan to go through with suicide but she was expending more for a while. she said that before taking her meds this year she was thinking of ending her life.</p>	<p>If something stood out to you or it was abnormal, explain its potential cause or patterns that you noticed. Describe any similar situations you have experienced / as well as the similarities or differences between the experiences. Is your interpretation of the situation links to pathophysiology at all, if so - briefly explain. she feels that the family doesn't want her here so she is here with her. she was better before she was here. she was better in the past. she was a family member felt this same way and we got her the help she needed to help her feel wanted & loved. we surrounded her with love so she could no longer care</p>	<p>What additional assessment information do you need based upon your interpretation? What can you do as a nursing student? What did you do? What could you do as a nurse? I would need to know the thing that she contribute in the feeling. she would be better for her. I would need to know her demographics with her family. I can help her to understand her feeling & why she feels this way. I can find out about her family history and where they thought started.</p>	<p>What is something that you learned? What is something that you might do differently in the future? What is something that you did well? What additional knowledge or skills do you need to help you with future situations like this. Describe any changes in your values or feelings based on this interaction. I learned that people hide their feelings well. they look well, but on the inside they may be breaking down. I can be there more in showing support. I'm supportive. I was supportive I listened & I allowed her to voice her feeling without judgement.</p>



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? hasn't had a plan to go through suicide with the thoughts she been having.

When? this year before getting on meds in January.

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

