

Mental Status Exam

Client Name <u>Lillian</u>		Date	
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 checked="" type="checkbox"/> Depressed <input type="checkbox"/> Euphoric <input type="checkbox"/> Irritable <input type="checkbox"/> Other			
Comments:			
COGNITION			
Orientation Impairment	<input type="checkbox"/> None	<input checked="" type="checkbox"/> Place	<input type="checkbox"/> Object <input checked="" type="checkbox"/> Person <input checked="" 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 type="checkbox"/> Other
Comments:			
PERCEPTION			
Hallucinations	<input type="checkbox"/> None	<input type="checkbox"/> Auditory	<input type="checkbox"/> Visual <input type="checkbox"/> Other
Other	<input 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 type="checkbox"/> Good	<input type="checkbox"/> Fair	<input checked="" type="checkbox"/> Poor Comments:
JUDGMENT	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input checked="" type="checkbox"/> Poor Comments: