Mental Status Exam

Client Name [redacted] C. T.	Date 9/22/23

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: "Very Good"

COGNITION

Orientation Impairment	AOx4 ☑ 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: No active thoughts or passive thoughts of suicide but has a history of attempted suicide.

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☐ Stereotyped ☐ Aggressive ☐ Bizarre ☐ Withdrawn ☐ Other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? Hanging himself w/ an ace bandage. Tied it around the ceiling fan and got a chair and kicked the chair from out from under him. He dangled for a minute then the whole ceiling fan came down.

   When? Last Thursday

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: N/A

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

CAGE QUESTIONNAIRE

1. Have you ever felt you ought to **CUT** down on your drinking? **YES / NO**
2. Have people **ANNOYED** you by criticising your drinking? **YES / NO**
3. Have you ever felt **GUILTY** about your drinking? **YES / NO**
4. Have you ever had a drink in the **MORNING** to alleviate withdrawal symptoms, or get rid of a hangover (Eye-opener)? **YES / NO**

SCORING
Two or more positive responses = probable alcohol problem