

Mental Status Exam

Client Name <u>Dylan McElhaney</u>		Date <u>10/13/23</u>	
OBSERVATIONS			
Appearance	<input checked="" type="checkbox"/> Neat	<input type="checkbox"/> Disheveled	<input type="checkbox"/> Inappropriate
Speech	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Tangential	<input type="checkbox"/> Pressured
Eye Contact	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Intense	<input type="checkbox"/> Avoidant
Motor Activity	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Restless	<input type="checkbox"/> Tics
Affect	<input type="checkbox"/> Full	<input type="checkbox"/> Constricted	<input checked="" type="checkbox"/> Flat
Comments:			
MOOD			
<input type="checkbox"/> Euthymic <input type="checkbox"/> Anxious <input type="checkbox"/> Angry <input type="checkbox"/> Depressed <input type="checkbox"/> Euphoric <input type="checkbox"/> Irritable <input checked="" type="checkbox"/> Other			
Comments: <u>positive "Good"</u>			
COGNITION			
Orientation Impairment	<input checked="" type="checkbox"/> None	<input type="checkbox"/> Place	<input type="checkbox"/> Object
Memory Impairment	<input checked="" type="checkbox"/> None	<input type="checkbox"/> Short-Term	<input type="checkbox"/> Long-Term
Attention	<input 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
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
Homicidality	<input checked="" type="checkbox"/> None	<input type="checkbox"/> Aggressive	<input type="checkbox"/> Intent
Delusions	<input checked="" type="checkbox"/> None	<input type="checkbox"/> Grandiose	<input type="checkbox"/> Paranoid
Comments: <u>No</u> ^{Now} <u>Passive or Active thoughts of S.I. Currently</u> ^{3 days prior}			
BEHAVIOR			
<input checked="" type="checkbox"/> Cooperative	<input type="checkbox"/> Guarded	<input type="checkbox"/> Hyperactive	<input type="checkbox"/> Agitated
<input type="checkbox"/> Stereotyped	<input type="checkbox"/> Aggressive	<input type="checkbox"/> Bizarre	<input type="checkbox"/> Withdrawn
Comments:			
INSIGHT	<input type="checkbox"/> Good	<input checked="" type="checkbox"/> Fair	<input type="checkbox"/> Poor
Comments:			
JUDGMENT	<input checked="" type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
Comments: <u>"I'd call 911"</u>			

Good →

walking by a house on fire.

DRUG USE QUESTIONNAIRE (DAST-20)

Name: Dylan McElhane DOB 9/10/04 Date: 10/13/23

The following questions concern information about your possible involvement with drugs not including alcoholic beverages during the past 12 months. Carefully read each statement and decide if your answer is "Yes" or "No". Then, circle the appropriate response beside the question. Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

In the statements "drug abuse" refers to:

- the use of prescribed or over the counter drugs in excess of the directions and
- any non-medical use of drugs.

The various classes of drugs may include: cannabis (e.g. marijuana, hash), solvents, tranquilizers (e.g. Valium), barbiturates, cocaine, stimulants (e.g. speed), hallucinogens (e.g. LSD) or narcotics (e.g. heroin). Remember that the questions do not include alcoholic beverages.

No	Questions	Response	
1.	Have you used drugs other than those required for medical reasons?	<input checked="" type="radio"/> Yes	<input type="radio"/> No
2.	Have you abused prescription drugs? <u>Colonopin, Narc, Methadone</u>	<input checked="" type="radio"/> Yes	<input type="radio"/> No
3.	Do you abuse more than one drug at a time?	<input checked="" type="radio"/> Yes	<input type="radio"/> No
4.	Can you get through the week without using drugs?	<input checked="" type="radio"/> Yes	<input type="radio"/> No
5.	Are you always able to stop using drugs when you want to?	<input type="radio"/> Yes	<input checked="" type="radio"/> No
6.	Have you had "blackouts" or "flashbacks" as a result of drug use?	<input checked="" type="radio"/> Yes	<input type="radio"/> No
7.	Do you ever feel bad or guilty about your drug use?	<input checked="" type="radio"/> Yes	<input type="radio"/> No
8.	Does your spouse (or parents) ever complain about your involvement with drugs?	<input type="radio"/> Yes	<input checked="" type="radio"/> No
9.	Has drug abuse created problems between you and your spouse or your parents?	<input checked="" type="radio"/> Yes	<input type="radio"/> No
10.	Have you lost friends because of your use of drugs?	<input checked="" type="radio"/> Yes	<input type="radio"/> No
11.	Have you neglected your family because of your use of drugs?	<input checked="" type="radio"/> Yes	<input type="radio"/> No
12.	Have you been in trouble at work because of drug abuse?	<input type="radio"/> Yes	<input checked="" type="radio"/> No
13.	Have you lost a job because of drug abuse?	<input type="radio"/> Yes	<input checked="" type="radio"/> No
14.	Have you gotten into fights when under the influence of drugs?	<input checked="" type="radio"/> Yes	<input type="radio"/> No
15.	Have you engaged in illegal activities in order to obtain drugs?	<input checked="" type="radio"/> Yes	<input type="radio"/> No
16.	Have you been arrested for possession of illegal drugs?	<input type="radio"/> Yes	<input checked="" type="radio"/> No
17.	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	<input checked="" type="radio"/> Yes	<input type="radio"/> No
18.	Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)?	<input checked="" type="radio"/> Yes	<input type="radio"/> No
19.	Have you gone to anyone for help for a drug problem?	<input checked="" type="radio"/> Yes	<input type="radio"/> No
20.	Have you been involved in a treatment program specifically related to drug use? <u>Brynmaur (Chicago) Mental Health + Drug Abuse</u>	<input checked="" type="radio"/> Yes	<input type="radio"/> No

SCORE: 15

DAST Scoring: Each "Yes" response = 1 point, except questions 4 & 5. For questions 4 & 5 only, a "No" response = 1 point.

A score of 6 points or more = substance abuse problem (abuse/dependence).