Mental Status Exam

Client Name [redacted] AB	Date [redacted] 3-8-24

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: sleep, binge

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: Planned to kill herself by hitting head on wall

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☐ Stereotyped	☐ Aggressive	☐ Bizarre	☐ Withdrawn	☐ Other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? "by banging her head" and "slicing her throat with butter knife"

When? Patient did not state when.

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