

### Mental Status Exam

Client Name		Date	
<b>OBSERVATIONS</b>			
Appearance	<input type="checkbox"/> Neat	<input type="checkbox"/> Disheveled	<input type="checkbox"/> Inappropriate
Speech	<input type="checkbox"/> Normal	<input type="checkbox"/> Tangential	<input type="checkbox"/> Pressured
Eye Contact	<input type="checkbox"/> Normal	<input type="checkbox"/> Intense	<input type="checkbox"/> Avoidant
Motor Activity	<input type="checkbox"/> Normal	<input type="checkbox"/> Restless	<input type="checkbox"/> Tics
Affect	<input type="checkbox"/> Full	<input type="checkbox"/> Constricted	<input type="checkbox"/> Flat
Comments:			
<b>MOOD</b>			
<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 type="checkbox"/> Other			
Comments:			
<b>COGNITION</b>			
Orientation Impairment	<input type="checkbox"/> None	<input type="checkbox"/> Place	<input type="checkbox"/> Object
Memory Impairment	<input 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:			
<b>PERCEPTION</b>			
Hallucinations	<input type="checkbox"/> None	<input type="checkbox"/> Auditory	<input type="checkbox"/> Visual
Other	<input type="checkbox"/> None	<input type="checkbox"/> Derealization	<input type="checkbox"/> Depersonalization
Comments:			
<b>THOUGHTS</b>			
Suicidality	<input type="checkbox"/> None	<input type="checkbox"/> Ideation	<input type="checkbox"/> Plan
Homicidality	<input type="checkbox"/> None	<input type="checkbox"/> Aggressive	<input type="checkbox"/> Intent
Delusions	<input type="checkbox"/> None	<input type="checkbox"/> Grandiose	<input type="checkbox"/> Paranoid
Comments:			
<b>BEHAVIOR</b>			
<input 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 Withdrawn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:			
<b>INSIGHT</b>	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
Comments:			
<b>JUDGMENT</b>	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
Comments:			

**Client Name:** C.A.

**Date:** 03/29/024

**Observations**

Appearance: Disheveled      Speech: Normal      Eye Contact: Normal  
 Motor Activity: Normal      Affect: Full

**Mood**

Anxious, Irritable

**Cognition**

Orientation Impairment: None      Memory Impairment: None  
 Attention: Distracted

**Perception**

Hallucinations: None      Other: None

**Thoughts**

Suicidality: Plan      Homicidally: None      Delusions: None

**Behavior**

Cooperative, Irritated

## Insight

Good

## Judgment

Poor, "I'd take the money"

Noticing	Interpreting	Responding	Reflecting
What did you notice during your <b>mental status examination</b> of the client? Were there any assessments that were abnormal or that stood out to you?	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.	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?	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.

**Noticing:** Everything seemed normal pertaining to the patient. The nursing student talked to the patient prior to the assessment, and the patient asked if the nursing student would assess her and ask her questions. The nursing student said yes and started to ask the patient questions pertaining to the Mental Status Exam. The patient appeared shy and quiet. When the nursing student asked the patient questions pertaining to the 'Thoughts' section, the patient started laughing.

**Interpreting:** The only thing that stood out to me was when the patient specifically asked me to assess her and ask her questions for the assignment. The patient was cooperative and talkative. The patient also started to laugh when asked questions about suicidal thoughts. Laughing can be the patient's way to deal with the trauma or stress. The patient might not think the questions are serious. She may use humor to cope with the fact that she attempted suicide and still experiences suicidal thoughts.

**Responding:** More information that I could use is more about her past. It would be helpful to know more about the full situation that the patient is going through and experienced prior to admission. I did ask a couple of

questions regarding her suicide attempt that were helpful to the assessment and my education. The therapeutic communication I did was staying serious and neutral even when the patient started to laugh. I also asked her if she usually uses humor to cope, and the patient said yes.

**Reflecting:** I learned that younger kids go through a lot of stress and trauma as well. I learned that everyone experiences and copes with things differently. I think I did well during the assessment to stay serious but yet neutral and nonjudgmental.

NIMH TOOLKIT



## 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? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 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

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1. Yes
2. Yes
3. Yes
4. Yes; How? "overdose"; When? "Wednesday, March 21<sup>st</sup>"
5. Yes; Describe: "overdosing again"

Noticing	Interpreting	Responding	Reflecting
<p>Why did you choose this <b>additional assessment</b>? What did you notice during your <b>additional assessment</b> of the client? Were there any assessments that were abnormal or that stood out to you?</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.</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?</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.</p>

**Noticing:** I chose this assessment because the patient was admitted to the facility for a suicide attempt. I noticed that when asked the questions, the patient started to laugh. I also noticed that after I asked the questions and the patient started to think about her answer, she became more serious and

stopped smiling and laughing. Nothing seemed to stand out about the patient.

**Interpreting:** This was the first assessment that when asked if they had suicidal thoughts, they said yes. Some people I have assessed said yes to one question, but no one I've ever assessed said yes to all of them. I think this patient wanted someone to talk to, and I think she really wanted someone to know she was having suicidal thoughts.

**Responding:** I don't think any additional information is needed for this assessment. The patient is having suicidal thoughts and is a high suicide risk. It is important to implement suicide precautions now and assess the patient further. Something I could do as a nurse is further assess the patient, put her on suicide precautions, and make her a 1:1.

**Reflecting:** I learned that this patient copes with her past and the fact that she is suicidal by using humor. This is a coping mechanism many people use. Although it is not ideal, it is a coping method that may temporarily help the patient cope. I valued this exchange with the patient, and I hope she gets the help she deserves.