

Mental Status Exam

Client Name M.B.		Date 9-8-25			
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 type="checkbox"/> Normal	<input type="checkbox"/> Intense	<input checked="" 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 type="checkbox"/> Full	<input type="checkbox"/> Constricted	<input checked="" type="checkbox"/> Flat	<input type="checkbox"/> Labile	<input type="checkbox"/> Other
Comments:					
MOOD					
<input type="checkbox"/> Euthymic <input type="checkbox"/> Anxious <input type="checkbox"/> Angry <input checked="" type="checkbox"/> Depressed <input type="checkbox"/> Euphoric <input type="checkbox"/> Irritable <input checked="" type="checkbox"/> Other					
Comments: client was annoyed					
COGNITION					
Orientation Impairment	<input checked="" type="checkbox"/> None	<input type="checkbox"/> Place	<input type="checkbox"/> Object	<input type="checkbox"/> Person	<input 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 checked="" type="checkbox"/> Distracted	<input type="checkbox"/> Other		
Comments: client focused on writing and coloring					
PERCEPTION					
Hallucinations	<input checked="" type="checkbox"/> None	<input type="checkbox"/> Auditory	<input type="checkbox"/> Visual	<input type="checkbox"/> Other	
Other	<input checked="" type="checkbox"/> None	<input type="checkbox"/> Derealization	<input type="checkbox"/> Depersonalization		
Comments:					
THOUGHTS					
Suicidality	<input type="checkbox"/> None	<input type="checkbox"/> Ideation	<input checked="" type="checkbox"/> Plan	<input checked="" type="checkbox"/> Intent	<input type="checkbox"/> Self-Harm
Homicidality	<input type="checkbox"/> None	<input checked="" 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: client wanted to hurt their friend					
BEHAVIOR					
<input checked="" type="checkbox"/> Cooperative	<input type="checkbox"/> Guarded	<input type="checkbox"/> Hyperactive	<input checked="" 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 checked="" type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	Comments:	
JUDGMENT	<input checked="" type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	Comments:	



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? cutting thighs in shower to bleed out and die

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