Mental Status Exam

Client Name	Hargis Brian / Conrad, Mollie	Date	9/~~10~~ 22/25

OBSERVATIONS

AD: 9/10/25

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: The pt seemed happy and excited

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:

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☐ Stereotyped ☐ Aggressive ☐ Bizarre ☐ Withdrawn ☐ Other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? Took a bunch of Pills

   When? like 8 years ago

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