

# Mental Status Exam

11 years old  
1/14/2014

Client Name <b>Zuri Alexander</b>		Date <b>9/28/25</b>	
<b>OBSERVATIONS</b> → can be calm if not provoked			
Appearance	<input 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 checked="" type="checkbox"/> Restless	<input type="checkbox"/> Tics
Affect	<input checked="" type="checkbox"/> Full	<input type="checkbox"/> Constricted	<input type="checkbox"/> Flat
Comments: <b>Hyperactive</b>			
<b>MOOD</b>			
<input type="checkbox"/> Euthymic <input type="checkbox"/> Anxious <input type="checkbox"/> Angry <input type="checkbox"/> Depressed <input type="checkbox"/> Euphoric <input checked="" type="checkbox"/> Irritable <input type="checkbox"/> Other			
Comments: <b>wants to go home</b>			
<b>COGNITION</b>			
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 checked="" type="checkbox"/> Normal	<input checked="" type="checkbox"/> Distracted	<input type="checkbox"/> Other
Comments: <b>ADHD diagnosis</b>			
<b>PERCEPTION</b>			
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: <b>N/A</b>			
<b>THOUGHTS</b>			
Suicidality	<input type="checkbox"/> None	<input checked="" type="checkbox"/> Ideation	<input type="checkbox"/> Plan
Homicidality	<input type="checkbox"/> None	<input checked="" type="checkbox"/> Aggressive	<input type="checkbox"/> Intent
Delusions	<input checked="" type="checkbox"/> None	<input type="checkbox"/> Grandiose	<input type="checkbox"/> Paranoid
Comments: <b>N/A</b>			
<b>BEHAVIOR</b>			
<input checked="" type="checkbox"/> Cooperative	<input type="checkbox"/> Guarded	<input checked="" 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>easily bothered by other girls, yells a lot</b>			
<b>INSIGHT</b>	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input checked="" type="checkbox"/> Poor
Comments: <b>acts out of impulse</b>			
<b>JUDGMENT</b>	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input checked="" type="checkbox"/> Poor
Comments: <b>N/A</b>			



# 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? NO, ideas  
 (client would not describe ideas to me.)

When? "Not recently"

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: N/A

### 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

