

Mental Status Exam

Client Name		Date	
OBSERVATIONS			
Appearance	<input type="checkbox"/> Neat	<input type="checkbox"/> Disheveled	<input type="checkbox"/> Inappropriate
	<input type="checkbox"/> Bizarre	<input type="checkbox"/> Other	
Speech	<input 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 type="checkbox"/> Avoidant
	<input type="checkbox"/> Other		
Motor Activity	<input 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 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 type="checkbox"/> Depressed <input type="checkbox"/> Euphoric <input type="checkbox"/> Irritable <input type="checkbox"/> Other			
Comments:			
COGNITION			
Orientation Impairment	<input type="checkbox"/> None	<input type="checkbox"/> Place	<input type="checkbox"/> Object
	<input type="checkbox"/> Person	<input type="checkbox"/> Time	
Memory Impairment	<input type="checkbox"/> None	<input type="checkbox"/> Short-Term	<input type="checkbox"/> Long-Term
	<input type="checkbox"/> Other		
Attention	<input type="checkbox"/> Normal	<input type="checkbox"/> Distracted	<input type="checkbox"/> Other
Comments:			
PERCEPTION			
Hallucinations	<input type="checkbox"/> None	<input type="checkbox"/> Auditory	<input type="checkbox"/> Visual
	<input type="checkbox"/> Other		
Other	<input type="checkbox"/> None	<input type="checkbox"/> Derealization	<input type="checkbox"/> Depersonalization
Comments:			
THOUGHTS			
Suicidality	<input type="checkbox"/> None	<input type="checkbox"/> Ideation	<input type="checkbox"/> Plan
	<input type="checkbox"/> Intent	<input type="checkbox"/> Self-Harm	
Homicidality	<input type="checkbox"/> None	<input type="checkbox"/> Aggressive	<input type="checkbox"/> Intent
	<input type="checkbox"/> Plan		
Delusions	<input type="checkbox"/> None	<input type="checkbox"/> Grandiose	<input type="checkbox"/> Paranoid
	<input type="checkbox"/> Religious	<input type="checkbox"/> Other	
Comments:			
BEHAVIOR			
<input type="checkbox"/> Cooperative	<input type="checkbox"/> Guarded	<input type="checkbox"/> Hyperactive	<input 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 type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
Comments:			
JUDGMENT	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
Comments:			