

Biopsychosocial Assessment-Part B: Mental Status Exam

Name of Client _____ Record #: _____

**Categories and Descriptions**

(*Complete this section only if Psychiatric Evaluation is done after admission process.)

Speech	<input type="checkbox"/> Coherent <input type="checkbox"/> Mute	<input type="checkbox"/> Rapid <input type="checkbox"/> Soft	<input type="checkbox"/> Pressured <input type="checkbox"/> Stuttering	<input type="checkbox"/> Slurring <input type="checkbox"/> Other	<input type="checkbox"/> Slow <input type="checkbox"/> Incoherent
Mood	<input type="checkbox"/> Sad <input type="checkbox"/> Somber	<input type="checkbox"/> Anxious <input type="checkbox"/> Happy	<input type="checkbox"/> Fearful <input type="checkbox"/> Tearful	<input type="checkbox"/> Hopeless <input type="checkbox"/> Angry/Hostile	<input type="checkbox"/> Helpless <input type="checkbox"/> Other
Affect	<input type="checkbox"/> Appropriate	OR	<input type="checkbox"/> Flat	<input type="checkbox"/> Blunted	<input type="checkbox"/> Labile <input type="checkbox"/> Incongruent
Motor Activity	<input type="checkbox"/> Appropriate <input type="checkbox"/> Pacing	<input type="checkbox"/> Tics <input type="checkbox"/> Catatonic	<input type="checkbox"/> Tremulous <input type="checkbox"/> Restless	<input type="checkbox"/> Sedated <input type="checkbox"/> Motor Retardation	<input type="checkbox"/> Physically Assaultive <input type="checkbox"/> Scratching/Picking
Perceptions	<input type="checkbox"/> Appropriate	OR	Hallucinations (check type) <input type="checkbox"/> Visual <input type="checkbox"/> Tactile		<input type="checkbox"/> Auditory <input type="checkbox"/> Gustatory <input type="checkbox"/> Olfactory
Thought Content	<input type="checkbox"/> Appropriate	OR	Obsessions Delusions (check type) <input type="checkbox"/> Somatic <input type="checkbox"/> Religious <input type="checkbox"/> Distorted Body Image		<input type="checkbox"/> Phobias <input type="checkbox"/> Somatization <input type="checkbox"/> Grandiose <input type="checkbox"/> Paranoid <input type="checkbox"/> Persecutory <input type="checkbox"/> Control
Thought Processes	<input type="checkbox"/> Intact <input type="checkbox"/> Loose Associations	<input type="checkbox"/> Perseveration	<input type="checkbox"/> Flight of Ideas	<input type="checkbox"/> Tangentiality	<input type="checkbox"/> Circumstantiality
Consciousness	<input type="checkbox"/> Alert	<input type="checkbox"/> Confused	<input type="checkbox"/> Sedated	<input type="checkbox"/> Stuporous	<input type="checkbox"/> Intoxicated
Orientation	<input type="checkbox"/> Orientated x4	Orientated to		<input type="checkbox"/> Time <input type="checkbox"/> Situation/Circumstance	<input type="checkbox"/> Place <input type="checkbox"/> Person
Memory	<input type="checkbox"/> Intact	<input type="checkbox"/> Poor Remote	<input type="checkbox"/> Poor Immediate	<input type="checkbox"/> Confabulation	
Attention Concentration	<input type="checkbox"/> Attends	<input type="checkbox"/> Easily Distracted	<input type="checkbox"/> Unable to attend		
Judgment	<input type="checkbox"/> Reasonable	<input type="checkbox"/> Mildly Impaired	<input type="checkbox"/> Significantly impaired		
Insight	<input type="checkbox"/> Present	<input type="checkbox"/> Poor	<input type="checkbox"/> Denial of Illness	<input type="checkbox"/> Blames outside factors	

Summary/Recommendations/Comments: _____

Mental Status Exam Completed By: _____

Signature: _____ Date: _____

Printed Name/Credentials/Title: _____

Devereux Georgia Treatment Network, 1291 Stanley Road, Kennesaw, Georgia 30152

Phone: 770-427-0147 - Fax: 678-213-0251 - www.fostercaredevga.org

Admission Assessment

Mental Status Exam Form Word Document

Jessica J Manson



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