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Looking for a mental status exam example to use when evaluating a client’s presentation and mental health? This article provides mental status exam examples, a mental status exam template, and information on how to conduct a mental status exam (MSE).Whether you’re a therapist, social worker, or provide crisis support, you’ll be involved in evaluating a client’s mental health and presentation—often by conducting an MSE. It can be challenging to remember all the components and terminology, especially if you’re a recently graduated clinician or new to providing mental health care. Along with the mental status exam template, this article includes mental status examples, complete with mental status questions, a mental status examination sample report PDF, and more.Customize the mental status exam template from this article to fit your client’s needs, or download the mental status examination PDF and save it to your electronic health record (EHR) for repeated use. What is a mental status exam (MSE)?A mental status exam assesses cognitive and behavioral functioning during an encounter with a client. Depending on the type of clinician performing an MSE, they may test multiple cognitive functions and/or use different clinical measures. We’ve provided some mental status exam examples below for various situations. Typically, therapists use an MSE when completing a biopsychosocial assessment. The exam can also be readministered at various stages throughout the client’s treatment. In some instances, like when a therapist bills insurance, they may be required to complete a brief MSE within their electronic health record for each visit. Mental status exams are helpful because they provide valuable insights into a client’s mental health or current state and can be used to document a diagnosis, devise a treatment plan, and monitor client progress. Core components of a mental status exam templateAppearance and general behavior This section describes the individual’s physical appearance (grooming, attire, height, weight, age) and behavior (demeanor and mannerisms, levels of engagement/lack of cooperation, eye contact, and speech).Mood and affect In this section, clinicians observe the client’s emotional state and how they express themselves. For example, the clinician may note an anxious mood, but the client’s facial expression is incongruent, and they may present a different emotional state.Cognition This section measures the person’s awareness and executive function. Cognition is assessed in several areas:Thought process and content: This category observes the client’s responses and thoughts. For example, are they able to respond to questions with trust, or do they appear suspicious? Is their thought process organized? Does it demonstrate logic and reasoning?Delusions: This measure assesses if the client’s response is unremarkable, or if they show signs of aggravation, misinterpretation, or obsession.Perception: This measures how the client responds to stimuli. Do they observe the same things as others in the room or do they have a false auditory or visual perception?It’s important for a clinician to consider all relevant information when conducting an assessment, including noting risk factors, protective factors, and forces and barriers that may be impacting their access to resources. Risk factors History of involuntary hospitalizationsHistory of traumaNo current mental health support, with a history of mental health concerns requiring support (e.g., schizoaffective disorder or other psychotic disorders)The client has poor insight into their situationUnhoused, with limited social and financial resourcesStrained familial relationshipsProtective factorsCan advocate for their own needsClose relationships with family, who are a source of supportHousing with adequate resources for sustenanceGainful employmentSocial supportEstablished health care, including mental health careRacial and cultural factors to considerIt’s also important to consider other sociological and socioeconomic factors during a mental status examination. For example, people of color face numerous barriers to healthcare. Black Americans typically have less access to quality healthcare due to therapy deserts in communities of color—resulting in only one in three Black adults who need mental healthcare receiving it. A person of color is also more likely to experience systemic and structural racism, trauma, and oppression, which has a negative effect on mental health. Racism can also be present in health care. Provider bias and inequality of care contributes to stigma, a lack of cultural competency, and underdiagnosis or misdiagnosis of people of color.For example, a Black adult male is four times more likely to be diagnosed with schizophrenia than a white male. Indicating providers overemphasize psychotic symptoms in Black men, while mood symptoms of depression, for example, are often overlooked.Young people of color are also disproportionately affected by racial biases in healthcare. According to Mental Health America (MHA), BIPOC youth with mental or behavioral issues are often unfairly penalized and imprisoned, instead of receiving mental health services. Approximately 50-75% of youth in juvenile detention meet a diagnosis for a mental health condition.Yet in 2020, roughly 10% of Black adults in the United States did not have any form of health insurance—making it even more difficult to find and afford care and treatment. While many risk factors may be present for an individual in a mental status exam, it's crucial to consider them in context of forces of oppression that may also be contributing to the person’s circumstances. For example, given the prevalence of misdiagnosis in people of color, they may be less open and authentic with a white clinician and even feel unsafe. As clinicians, we can and should try to provide them with accessible and culturally competent resources within their community.Mental status exam examplesHere are two examples of scenarios in which a clinician might document a mental status exam:Situation An individual seeking therapy for depression.Mental status exam example Client is a 40-year-old white male, married, and seeking treatment for depression. They presented as well-groomed, clean shaven, maintained eye contact, and engaged during the assessment. In their intake paperwork and during the intake session, they reported feeling low, oftentimes crying, which was congruent with a depressed affect. The client believed the reason for their depression was due to the recent loss of their mother—showing insight, cohesion, and logical thought process and content. During the assessment, they appeared oriented, with unremarkable perception, and no signs of delusions. Risk assessment: The clinician administered an Ages and Stages Questionnaire (ASQ) screening as part of the intake paperwork and repeated this during the assessment. The client did not demonstrate suicidal ideation.Protective factors: The client reported to be in a loving marriage with a supportive partner, and having an active social life. While they are clearly impacted by their grief, they also mentioned being part of a close family, who are supporting one another in the grieving process. The client remains engaged in work and has several hobbies. Situation Crisis response call to a female who appeared to be experiencing hallucinations.Mental status exam example The crisis team responded to a police call regarding a white 30-year-old female they thought was experiencing psychosis. On arrival, the crisis team was greeted by the building manager where the client resides, and the crisis team observed the client walking in the yard outside their house. The building manager reported that the client broke into the main office last night, believing the staff had stolen some of their personal possessions. The client’s appearance was disheveled, they were wearing inappropriate clothing (their pajamas), and they appeared gaunt and below average weight for their age and height. Their mood was anxious and labile, with minimal eye contact. They appeared to be acutely distracted by external stimuli, including auditory and visual hallucinations to the extent that they were unable to engage in the assessment. The crisis team also observed the client mumbling to themselves, but with pressured speech, and they showed restless psychomotor activity, as they were unable to stand still. Taken together, the crisis team concluded the client’s cognition showed poor perception, impulse control, and judgment. Risk factors: The building manager reported the client lives alone. Protective factors: The building manager also mentioned that they contacted the client’s emergency contact, their sister, whom they have a close relationship with and is a solid source of support. The manager mentioned that their sister is on the way and had experience supporting their sister through these “episodes.”Mental status exam questions to askBelow are examples of questions to ask clients during each section of the exam:MoodHow would you describe your mood?What is your mood like generally?For example, would you describe yourself as happy, sad, angry, depressed, very happy, or frightened?Are these moods you feel all the time, or have you noticed a change? If so, why do you think that is?Thought processes and contentDo you ever see things that other people don’t see?Do you ever hear things others don’t?I noticed you looking to your right a lot. What do you see?Can you describe what you’re hearing at the moment?Do you ever feel suspicious of other people?CognitionWhat is today’s date?Who is the president of the United States?Do you know what time it is right now?What is your name and address?Repeat the following nine words: It’s a sunny day and the sky is blue.Suicidal ideationAccording to the ASQ Suicide Risk Screening Tool, questions to ask include:In the past few weeks, have you wished you were dead?In the past few weeks, have you felt that you or your family would be better off if you were dead?In the past week, have you been having thoughts of killing yourself?Have you ever tried to kill yourself?If the client answers yes to any of these, follow up by asking:Are you having thoughts of killing yourself right now?If the client answers yes to the follow-up question, this is an acute positive screen, and they should be evaluated for safety immediately. If they answer no to all of the preliminary questions, or to the last question, the clinician should move on to complete the ASQ assessment. There are also versions of this assessment for adults in inpatient and outpatient settings, along with a combined Patient Health Questionnaire (PHQ-9) and ASQ tool.How and when to use the mental status exam templateThe mental status exam template can be used in various situations, such as:Intake assessmentBiopsychosocial assessmentProgress notesCrisis situationsPrimary care settingsEmergency departmentsHow SimplePractice streamlines running your practiceSimplePractice is HIPAA-compliant practice management software with everything you need to run your practice built into the platform—from booking and scheduling to insurance and client billing.If you’ve been considering switching to an EHR system, SimplePractice empowers you to streamline appointment bookings, reminders, and rescheduling and simplify the billing and coding process—so you get more time for the things that matter most to you.Try SimplePractice free for 30 days. No credit card required. As behavioral health professionals, mastering the Mental Status Exam (MSE) is crucial for providing effective care to your clients. This guide will equip you with the knowledge and tools to conduct thorough MSEs, allowing you to identify certain mental health conditions more easily, and informing your treatment planning.In this blog, we'll cover the following:Key components of a mental status examinationA guide to conducting each part of the exam with examples and assessment techniquesA full example of a complete MSEPractical challenges and solutionsCultural considerations in MSE assessmentIf instead you're looking for a comprehensive guide on how to do a biopsychosocial examination, refer to this guide here.The Purpose of the Mental Status ExamThe Mental Status Exam is a structured assessment of a client's cognitive and emotional functioning at a specific point in time. It serves several crucial purposes:Provides a baseline of the client's mental stateAids in differential diagnosisHelps track changes in symptoms over timeInforms treatment planning and interventionsFacilitates communication with other healthcare providersYou'd want to do a brief mental status exam at the beginning of any new client relationship, to identify potential mental health conditions.Components of the Mental Status ExamA comprehensive mental status exam typically covers the following 10 components:Appearance and BehaviorAttitudeMotor ActivitySpeechMood and AffectThought ProcessThought ContentPerceptionCognitionInsight and JudgmentWe cover each of these in depth later in this article.What is a Mini Mental State Exam?In contrast to the comprehensive mental status exam (MSE), the "mini" mental state examination (MMSE) is a specific, structured screening tool designed primarily to assess cognitive impairment.It consists of a series of questions and tasks that focus on orientation, registration, attention and calculation, recall, and language.While the MSE is used broadly in mental health evaluations, the MMSE is particularly useful for detecting and monitoring cognitive decline, such as in cases of dementia or delirium.The MSE provides a broader picture of mental functioning, while the MMSE offers a more focused and quantifiable assessment of cognitive abilities.How to Conduct the Mental Status Exam1. Appearance and BehaviorIn this section, observe and document the following:Age, gender, ethnicityAttire and groomingPosture and eye contactAny notable physical characteristics or abnormalitiesTypical Example: "35-year-old Caucasian male, appears stated age. Well-groomed, dressed in business casual attire. Makes appropriate eye contact and sits with an open posture."Atypical Example: "35-year-old Caucasian male, appears older than stated age. Disheveled appearance with stained clothing and strong body odor. Avoids eye contact and sits hunched over with crossed arms."Assessment Prompts:"Can you tell me about your typical daily routine, including how you prepare for the day?""How would you describe your energy levels lately?"2. AttitudeAssess the client's approach to the interview: Cooperative, guarded, hostile, seductive, etc.Typical Example: "Client demonstrates a cooperative attitude, readily engaging in the assessment process."Atypical Example: "Client exhibits a guarded and somewhat hostile attitude, providing minimal responses and frequently challenging the purpose of questions."Assessment Prompts:"How do you feel about being here today?""What are your expectations for our session?"3. Motor ActivityNote the body language and any unusual movements or behaviors:Psychomotor agitation or retardationTics, tremors, or unusual mannerismsTypical Example: "Client displays normal psychomotor activity, with no unusual movements noted."Atypical Example: "Client exhibits significant psychomotor agitation, frequently shifting in the seat, tapping feet, and fidgeting with hands."Assessment Prompts:"Have you noticed any changes in your energy levels or ability to sit still recently?""Do you ever experience any involuntary movements or sensations?"4. SpeechHere we evaluate the client's speech patterns. Look at the following elements -Rate: pressured, rapid, normal, slowVolume: loud, soft, normalTone: monotone, expressiveContent: relevant, coherent, tangentialTypical Example: "Speech is of normal rate, volume, and tone. Content is relevant and coherent."Atypical Example: "Speech is rapid and pressured, with increased volume. Content is tangential, frequently veering off-topic."Assessment Prompts:"How would you describe your typical speaking style?""Have others commented on changes in your speech recently?"5. Mood and AffectHere we evaluate a patient's emotional state. Mood: This is the client's self-reported emotional state. We use the client's subjective descriptions of their emotions. Affect: This is the observed expression of emotion. Remember the ABCs of Affect: A - Affect: The outward expression of emotion B - Behavior: How the emotion is expressed through actions C - Cognition: The thoughts associated with the emotionWhen assessing affect, consider:Range: full, restricted, flatIntensity: normal, blunted, exaggeratedStability: stable, labileAppropriateness to contentTypical Example: "Client reports mood as 'pretty good.' Affect is full range, appropriate to content, and congruent with reported mood."Atypical Example: "Client reports feeling 'numb.' Affect is flat, with minimal facial expression or vocal inflection, incongruent with the emotional content being discussed."Assessment Prompts:"How would you describe your mood over the past week?""On a scale of 1-10, with 10 being the best you've ever felt and 1 being the worst, where would you rate your mood right now?""Have you noticed any changes in your ability to feel pleasure or interest in activities?"6. Thought ProcessHere we evaluate the patient's thought processes, like the flow and organization of thoughts:Logical and goal-directedCircumstantialTangentialFlight of ideasLoose associationsThought blockingTypical Example: "Thought process is logical and goal-directed, with client able to provide clear and relevant responses."Atypical Example: "Thought process is tangential, with client frequently going off on unrelated tangents and struggling to return to the original topic."Assessment Prompts:"Can you walk me through your typical day, from morning to night?""How would you describe your ability to concentrate and focus lately?"7. Thought ContentHere we are assessing for the presence of:DelusionsObsessionsPhobiasSuicidal and homicidal ideationTypical Example: "No evidence of delusions, obsessions, or phobias. Denies current suicidal or homicidal ideation."Atypical Example: "Client expresses paranoid delusions, believing that the government is monitoring their thoughts through implanted devices. Reports frequent intrusive thoughts about contamination."Assessment Prompts:"Do you ever have thoughts that you can't seem to get out of your head?""Have you ever felt like others can read your thoughts or control your mind?""Do you ever have thoughts of harming yourself or others?"8. PerceptionEvaluate for any perceptual disturbances:Hallucinations (specify type: auditory, visual, tactile, etc.)IllusionsDepersonalizationDerealizationTypical Example: "No reported or observed perceptual disturbances."Atypical Example: "Client reports auditory hallucinations of voices commenting on their actions. Also describes episodes of depersonalization, feeling detached from their body."Assessment Prompts:"Have you ever seen, heard, or felt things that others don't seem to experience?""Do you ever feel disconnected from yourself or your surroundings?"9. CognitionHere, use the GOAL CRAMP mnemonic: G - General alertness O - Orientation (person, place, time, situation) A - Attention and concentration L - Language C - CalculationR - Right/left orientationA - AbstractionM - Memory (immediate, recent, remote)P - PraxisTypical Example: "Alert and oriented x4. Attention, concentration, and memory appear intact. Able to perform simple calculations and demonstrate abstract thinking."Atypical Example: "Oriented to person and place, but confused about time. Attention span is limited, struggling with serial 7s. Recent memory impaired, unable to recall events from earlier in the day."Assessment Prompts:"Can you tell me today's date, including the day, month, and year?""I'm going to say three words. Please repeat them back to me, and try to remember them because I'll ask you to recall them later: Apple, Penny, Table.""Can you count backwards from 100 by 7s?"10. Insight and JudgmentAssess the client'sUnderstanding of their condition (insight)Decision-making ability (judgment)Typical Example: "Client demonstrates good insight into their anxiety, recognizing its impact on daily functioning. Judgment appears sound, as evidenced by seeking professional help and adhering to treatment recommendations."Atypical Example: "Client lacks insight into their manic symptoms, believing increased energy and risky behaviors are signs of improved mental health. Judgment is impaired, as demonstrated by recent impulsive financial decisions."Assessment Prompts:"What do you think might be causing the difficulties you're experiencing?""How do you think these issues are affecting your life?""What steps have you taken to address these problems?"Example of a Full Mental Status ExamHere's a comprehensive example of an MSE write-up:"Jane Doe is a 42-year-old African American female who presented for evaluation of depressive symptoms. She appeared her stated age, was neatly groomed, and dressed appropriately in casual attire. Her eye contact was intermittent, and she displayed psychomotor retardation, moving and speaking slowly.Jane's attitude was cooperative but guarded. Her speech was soft and slow, with increased latency in responses. She described her mood as "hopeless," and her affect was constricted, predominantly sad, and congruent with reported mood.Thought process was logical and goal-directed, albeit slow. Thought content revealed passive suicidal ideation without plan or intent, and feelings of worthlessness. She denied hallucinations, delusions, or obsessions.Jane was alert and oriented x4. Attention and concentration were mildly impaired, struggling with serial 7s but able to spell "WORLD" backwards. Recent memory was intact, recalling 3/3 objects after 5 minutes. Abstract thinking and judgment were fair.Jane demonstrated good insight into her depression, recognizing the need for treatment. No obvious cognitive deficits were noted during the examination."Using AI for Mental Status ExamToday, AI tools can automatically write a high-quality mental status exam. One exciting development in this area is the automation of therapy notes using artificial intelligence, which offers significant time-saving potential for therapists.Automating MSE notes with SupanoteSupanote is an AI platform that can automatically write mental status exams for you, directly from your sessions, covering all the topics above. Here are some key features and benefits:Direct Session Capture: Supanote can listen directly to therapy sessions and automatically generate a high-level MSE based on the conversation.Built-in MSE Template: The system comes with a pre-configured MSE note template, ensuring that all generated notes follow the correct format and structure.HIPAA Compliance: Supanote is designed to be HIPAA-compliant, providing a high level of security for sensitive patient information. This compliance is crucial for maintaining patient confidentiality and meeting regulatory requirements.Time-Saving: By automating the note-taking process, Supanote can potentially save therapists hours of documentation time each week. This allows clinicians to focus more on patient care and less on administrative tasks.Below is an example of a sample MSE auto-generated by Supanote AI based on a session. You can also edit the template on Supanote to include the specific sections you'd like.The gap in Supanote and other AI tools is that they don't yet process the visuals - e.g., the patient's facial expressions. So while you will get an MSE, it is best to go through and edit it and update with your own observations (the notes are directly editable).The MSEs generated by these tools are not intended to be a replacement to your clinical judgement, but as supporting tools to save time for clinicians.Tips for Conducting an Effective MSEStart with open-ended questions to build rapport before moving to more specific inquiries.Use natural transitions between topics to cover different aspects of the MSE.Pay attention to non-verbal cues throughout the session.Practice active listening and reflection to encourage client disclosure.Be prepared to pause the assessment if the client becomes distressed or needs a break.Document observations in real-time or immediately after the session to ensure accuracy.Regularly review and refine your MSE skills through peer consultation and continuing education.Practical Challenges and Solutions1. Time ManagementChallenge: Conducting a thorough MSE can be time-consuming, especially in busy clinical settings.Solution: Prioritize key components based on presenting concerns. Integrate MSE questions naturally into the conversation. Use standardized brief cognitive assessments when appropriate.2. Balancing Standardization and IndividualizationChallenge: Adhering strictly to a standardized MSE format may miss important individual nuances.Solution: Use the standard MSE as a framework, but allow flexibility to explore areas of particular concern for each client. Document any deviations from the standard format and the rationale for them.3. Building Rapport While AssessingChallenge: Formal assessment can sometimes feel impersonal or intimidating to clients.Solution: Explain the purpose of the MSE to clients. Use a conversational tone and integrate assessment questions naturally into the discussion. Pay attention to the client's comfort level and take breaks if needed.4. Cultural CompetenceChallenge: Interpreting MSE findings accurately across diverse cultural backgrounds.Solution: Continuously educate yourself on cultural differences in mental health presentation. When unsure, ask clients about their cultural background and how it might influence their experiences. Consult with colleagues or cultural experts when needed.Common Pitfalls to AvoidRushing through the assessmentMaking assumptions based on appearance or initial impressionsOverlooking subtle signs of cognitive impairment or emotional distressFailing to consider cultural factors in interpretationUsing jargon or technical terms when documenting, rather than clear, descriptive languageWhen conducting an MSE, it's crucial to consider cultural factors that may influence a client's presentation.Here are some examples:Eye Contact: In some Asian and Middle Eastern cultures, direct eye contact with authority figures may be considered disrespectful. A client averting their gaze might be showing respect rather than indicating depression or anxiety.Emotional Expression: Some cultures value emotional restraint, while others encourage more open expression. A client from a culture that emphasizes stoicism may appear to have a restricted affect, even when experiencing intense emotions.Spiritual Beliefs: In certain African, Native American, or other indigenous cultures, hearing the voice of a deceased relative might be considered a comforting spiritual experience rather than a hallucination.Thought Content: Cultural beliefs about spirits, ancestral communication, or supernatural phenomena could be misinterpreted as delusions in a Western context.Personal Space: Cultures differ in their norms for personal space. A client who stands very close or far away may be adhering to their cultural norms rather than displaying unusual behavior.Always strive to understand the client's cultural background and how it might influence their presentation. When in doubt, respectfully ask the client about their cultural practices and beliefs.Mental Status Exam Template and Cheat SheetsBelow is a simple mental status exam cheat sheet you can use to refer to the different components of a mental status exam. It's a reference guide you can look at to make sure you covered all the individual components, and what's expected in each section.Also see below another cheat sheet with the assessment prompts/ questions you can use for each of the sectionsConclusionMastering the Mental Status Exam is an ongoing process that requires practice and refinement. By consistently applying the principles and techniques outlined in this guide, you'll enhance your clinical acumen and provide more targeted, effective care for your clients. Remember, the MSE is not just a checklist but a dynamic tool that, when used skillfully, can provide invaluable insights into your client's mental health and guide your therapeutic interventions.Keep this cheat sheet handy as a quick reference during your assessments, and don't hesitate to adapt it to your specific practice needs and client populations. With time and experience, conducting a comprehensive MSE will become second nature, allowing you to focus on building strong therapeutic relationships and delivering high-quality mental health care.FAQsHere are some common queries about Mental Status ExamsHow long should a Mental Status Exam take?A: Typically, a comprehensive mental status exam takes about 15-30 minutes. But don't sweat it if it takes longer when you're just starting out. With practice, you'll get faster and smoother!Do I need to cover every component of the mental status exam in every session?A: Not necessarily. While it's ideal to cover all bases, you can focus on the most relevant areas based on your client's presenting issues. Just make sure to document why you skipped certain parts.How often should I conduct a mental status exam ?A: At minimum, do a full MSE during the initial assessment. After that, it's good practice to do brief check-ins each session and a more thorough review periodically or when you notice significant changes.What if my client refuses to participate in certain parts of the MSE?A: Respect their boundaries, but document their refusal and any observations you can still make. Try to understand why they're hesitant – it might provide valuable clinical insights.How do I explain the purpose of an MSE to my clients?A: Keep it simple and friendly. You might say something like, "I'm going to ask you a few questions to get a clearer picture of how you're doing right now. This helps us understand your current needs better and plan the most effective treatment."Are there any standardized forms for conducting an MSE?A: While there's no universally standard form, many clinics and institutions have their own. Check with your workplace or professional association for recommended templates.How detailed should my MSE notes be?A: Aim for clear, concise, and objective observations. Use direct quotes when relevant, and always document any safety concerns thoroughly.Can I use an MSE with children or adolescents?A: Absolutely! Just adjust your language and expectations to be developmentally appropriate. Play-based assessments can be particularly useful for younger kids.What if I suspect cognitive impairment during an MSE?A: If you notice significant cognitive issues, it's a good idea to use more specific cognitive screening tools (like the MMSE or MoCA) and consider referring for neuropsychological testing.How do I improve my MSE skills?A: Practice, practice, practice! Conduct MSEs regularly, seek feedback from colleagues, review recorded sessions if possible, and stay updated with continuing education. The more you do it, the more natural it becomes.Remember, these FAQs are just the tip of the iceberg. Keep asking questions, stay curious, and never stop learning.ReferencesAmerican Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Arlington, VA: American Psychiatric Publishing. M. F., Folstein, S. E., & McHugh, P. R. (1975). "Mini-mental state": A practical method for grading the cognitive state of patients for the clinician. Journal of Psychiatric Research, 12(3), 189-198. 75)90026-6Groth-Marnat, G., & Wright, A. J. (2016). Handbook of psychological assessment (6th ed.). John Wiley & Sons. of+Psychological+Assessment%2C+6th+Edition-p-9781118960646Karasz, A., & Singelis, T. M. (2009). Qualitative and mixed methods research in cross-cultural psychology. Journal of Cross-Cultural Psychology, 40(6), 909-916. N., Freudenreich, O., & Querques, J. (2016). The mental status examination: A comprehensive approach to its components and performance. Psychiatric Clinics, 39(4), 605-621. J. (2014). The first interview (4th ed.). Guilford Press. MENTAL STATUS EXAMINATION: The patient presents with generalized psychomotor slowing and somewhat blunted affect. Cognition intact. Speech is considered to be within normal limits, maybe slightly slowed. No abnormal movements, tics or tremors are noted. Not psychotic. Denies any suicidal or homicidal ideation. Insight is very good. Intellect is considered to be average. Has quite serious intent with her questions and with her planning for future treatment and help regarding her mental health as well as her substance use.MENTAL STATUS EXAMINATION: Showed a medium-built male with labile affect. Oriented x3. Insight was poor. Judgment was very poor. Behavior was hyperactive. Denies any suicidal or homicidal ideations. Denies hallucinations. Memory appeared to be grossly intact. Cognitive functioning appeared to be impaired. Speech was pressured and rambling. Trend of thought showed ideas of grandeur and omnipotence. Mood was expansive but also was quick to change to anger. Intelligence was average. Reality testing appeared to be impaired.MENTAL STATUS EXAMINATION: The patient is alert and oriented. Dress and hygiene are fair. Looks his stated age. Calm and cooperative. Good eye contact. No psychomotor agitation or retardation. Speech is normal. No pressure of speech. No thought disorder. Thoughts are goal directed. Affect is euthymic and appropriate. No emotional blunting. The patient denied any audiovisual hallucinations. No delusions noted. Insight and judgment are fair. Impulse control is fair. The patient is cognitively intact.MENTAL STATUS EXAMINATION: This is a patient who appears to be of stated age. She is neatly groomed. She maintains good eye contact. Mood is mildly depressed. Speech is normal in rate, rhythm and volume. Mood and affect are mildly dysthymic. She denies any suicidal or homicidal ideation. She denies any psychotic symptoms. She denies any obsession, compulsion or phobia. She is alert and oriented. Insight and judgment are fair.MENTAL STATUS EXAMINATION: This is a patient who appears to be of stated age, casually and neatly dressed and in no acute distress. The patient engaged the examiner in a cooperative, friendly and polite manner. The patient demonstrated good eye contact. His speech was spontaneous with normal rate, rhythm and tone. His reaction time to questions was normal. While his affect was appropriate to the situation, his mood was euthymic with no evidence of depression, guilt feelings and suicidal or homicidal ideation at this time. His stream of mental activity was logical, relevant, coherent and goal directed with no evidence of flight of ideas, looseness of associations, thought blocking, psychomotor retardation, pressured speech, racing thoughts, circumstantiality or tangentiality. His thought content revealed no evidence of delusional ideation, interference or responses to internal stimuli, hallucinations, ideas of reference, mood swings, compulsions, obsessions, or any specific preoccupations. The patient was alert and oriented in all three spheres. His memory was intact including his immediate, recent past and remote memory. His attention and concentration were intact. His fund of general information was good. The patient was able to perform simple arithmetic calculations and serial subtraction by 7s. His comprehension and understanding were good. Therefore, his intelligence was estimated to be above average; consistent with his level of formal education. His abstraction of proverbs and symbolization were good. His judgment, insight and reliability appeared to be good.MENTAL STATUS EXAMINATION: This is a patient who is well groomed and appeared his stated age. There is no clinical evidence of psychomotor disturbance. He was able to maintain adequate eye contact. His speech was coherent, spontaneous, appropriate with normal rate, volume and rhythm. He described his mood as normal. Objectively, his mood was euthymic. His affect is full range, appropriate, with spontaneous emotional reactivity. There were no clinical features of affective or psychotic illness. His behavior is appropriate. His memory is intact for recent and remote events. He is well oriented to place, time and person. His concentration and attention were both adequate. He was able to do serial 7s and was able to add and subtract figures without any difficulty. His general level of intelligence and fund of general knowledge appears to be adequate. His level of personal hygiene is fairly good. He was able to communicate clearly and he was able to achieve goal directed ideas without any difficulty. He denied any suicidal or homicidal ideation. His level of abstract reasoning is intact. I was able to maintain adequate rapport with him throughout the interview and he was able to follow directions. He denied any ideation of worthlessness or hopelessness. He denied any auditory or visual hallucinations. He denied any preoccupations, illusions or phobias. He has very poor insight into the nature of his substance abuse.MENTAL STATUS EXAMINATION: Reveals a well-nourished, well-developed, athletic built female who looks her stated age. Hygiene and grooming are adequate. Initially, she was quite secretive about divulging any information about her unusual experience, asked that the door be closed and it was. The conversation from start to finish is effusive, voluminous, circumstantial, tangential and loosely organized but it is coherent. There are no abnormalities to the content of her thought; however, an illusionary experience is suspect, of many years’ duration and conversion symptoms. The content of her thought reveals grandiosity and expansiveness with respect to her own capacity to assess her symptoms. There are no abnormalities to the content of her thought and no perceptual disturbances. Fund of general knowledge is probably low average. Her mood is one of detachment and indifference; although, at the conclusion of the interview, she was tearful but more so because she seemed not to want to accept the psychiatric explanation for her possible symptomatology. Her attitude is self-centered. Her affect is labile, histrionic. Her demeanor is quite self-absorbed. Her memory is faulty due to her preoccupation with religious ideas and her own capacity for self-introspection and assessment. Her judgment is impaired by her obsession and fixation with this probable illusionary experience and her conversion symptoms of long years’ standing. Her insight is lacking and judgment, as stated, is impaired. No suicidal or homicidal ideation. She was too fixated to do proverb interpretation or simple arithmetical calculations. Her attention is limited due to the fact that she is so preoccupied.MENTAL STATUS EXAMINATION: This patient was appropriately dressed. Her hygiene was adequate. She was cooperative for the evaluation, and with prompting, she was able to remember some of the long-term information regarding her psychiatric treatments. Her mood was anxious. Her affect was mood congruent. Thought processing was goal directed and coherent. Thought content, she says she hears women mumbling but cannot make out what they are saying. She also describes this as not interfering or being intrusive in her daily life. She says she sees shadows only at night and not during the day, and those are not visual hallucinations. It is questionable whether she is having a true auditory hallucination since she does not hear these women mumbling as she does hear this physician’s voice. She describes it as “in my head.” She has no thoughts to harm herself or others. She does not self-mutilate. Her sleep is chronically poor regardless of what her mood is. She did not describe any symptom criteria for PTSD or OCD or panic episodes.MENTAL STATUS EXAMINATION: Today, the patient is moderately distracted and has thoughts that are slightly tangential. He is in a normal mood range without signs of being either in depression or mania currently. He does have a past history of frequent depressive episodes. There is a moderate amount of discouragement about his current legal situation, which we told him, would be expected at this point, but otherwise, he does not feel overwhelmingly hopeless, and he does not have any suicidal thoughts currently. There are no homicidal thoughts. He tends to think concretely but does have some insight into his situation. He realizes he needs more structure and needs to stay in treatment and have better compliance in the future so that he does not have difficulty with probation and treatment programs. Currently, his thoughts are connected, although slightly tangential. He is able to comprehend fairly well, and he has fairly good judgment at the current time. He seems motivated for treatment. He does not speak much about the physical abuse from early childhood and one has the impression that there may be more traumas. He said he is committed to staying in recovery from the drug and alcohol problems, and he has maintained sobriety in the recent past.MENTAL STATUS EXAMINATION: He is awake and alert. Thoughts are organized. He is uncooperative with the interview. He is not suicidal or homicidal. The patient denies any auditory or visual hallucinations or any paranoia. The patient’s mood is angry. Affect is irritable. He makes sarcastic remarks, and he is disrespectful. His speech is coherent and minimal. His eye contact is sporadic. No tremors. No EPS. His insight is limited, and he tends to blame others for all his problems.MENTAL STATUS EXAMINATION: Reveals a well-nourished, well-developed, attractive, small-statured female who looks her stated age. Her appearance is neat, clean and well groomed. She is accessible to examination and made an effort to be cooperative. Her attitude is friendly. Speech is coherent, relevant and goal directed. Thinking is well organized, and she is able to elaborate on her responses and shows insight into her drug use and drinking. There are no abnormalities to the content of her thought. There are no perceptual disturbances. Her mood, for the most part, is euthymic. Her affect likewise shows a good range and is appropriate. Her judgment is adequate on examination; however, impaired by history and failure to learn from the consequences of her illegal behavior. Insight, as stated, is partial in intellectual level. Fund of general knowledge is probably low average. There is no sign of any thoughts of wanting to harm others or herself. She is able to abstract proverbs. Her memory is fair. Sensorium is clear. She is able to perform simple arithmetical calculations. No abnormal involuntary movements are presentMENTAL STATUS EXAMINATION: The patient was alert. She was able to state the day of the week, the date, the month, the year, and the place. Motor activity: She is able to move all extremities without any difficulties. She does have a deficit to her right hand. General appearance: She was fairly groomed and fairly clean. She appears looking older than her stated age. There were no signs and symptoms of abnormal involuntary movements to any body parts noticed. Her affect was appropriate. Her mood was normal. Thought content was on topic and logical; however, she was noted to be very forgetful throughout the interview. There were no ideas of reference noted. The patient presents with a lot of thought blocking. Reports that she has difficulty remembering things and finishing her thoughts since her brain aneurysm surgery a couple of years ago. She denies any current or past signs and symptoms of audiovisual hallucinations or any other type of hallucinations when questioned. Her memory when tested, immediate recall was 3/3; short-term recall when tested was only 1/3. Her insight is impaired. Her judgment is also impaired. Attention and concentration are decreased as a result of a brain aneurysm surgery a couple of years prior. Since the surgery, she has difficulty with focus and concentration and gets easily distracted at times. Her interpretation of proverbs is concrete. Her level of intelligence is noted to be borderline. She denies having any difficulties with her growth and development. Reports that her functioning was normal prior to the removal of the brain aneurysm and that when in school, she attended regular classes. Denied attending special education classes. Suicidal and homicidal ideations, plans and intentions were denied when questioned. Her fund of knowledge was below adequate, again believed to be caused by removal of the brain aneurysm.MENTAL STATUS EXAMINATION: This is a (XX)-year-old Hispanic male. He was alert, oriented, and fairly cooperative. He was quite manipulative and demanding. His concentration and memory were intact. His speech was normal rate, flow and tone, goal directed. Language was appropriate. His mood was euthymic. Affect was a little edgy. No suicidal or homicidal ideation per se, but he did report that he may try to hurt himself if he does not get his way. The examiner did not find any psychosis on evaluation or disorganization. In thought process, he was quite goal directed, quite organized, and appeared to be working on a strategy. He did complain of ongoing auditory and visual hallucinations, but there was no evidence of disorganization or any other psychotic features on examination. There was no flight of ideas, loosening of association, tangentiality, or circumstantiality. He seems to have reasonable insight into his situation. His judgment though was somewhat impaired.MENTAL STATUS EXAMINATION: This female was appropriately dressed. Her hygiene was adequate. She appears her stated age. She seemed cooperative and reliable for this evaluation. Her mood was anxious. Her affect was mood congruent. Thought processing was goal directed and coherent. Thought content, there is no auditory or visual hallucinations or delusions. She does not have thoughts to harm herself or others and she does not self-mutilate. She is anxious and complains of chronic poor sleep. Cognition, she is alert and fully oriented. Her gross memory functions are intact. Her IQ appears to be borderline intellectual functioning, and her insights and judgments appear intact.MENTAL STATUS EXAMINATION: Reveals a tall, slender but athletic built woman who is alert, attentive, cooperative and accessible to examination. She appears older than her stated age. Hygiene and grooming are satisfactory. Her sensorium is clear. Motor activity is somewhat uneasy and restless. There are no abnormal involuntary movements present. Her affect is animated. Her mood is elated/elevated. No abnormalities to the content of her thought. No perceptual disturbances. Fund of general knowledge is estimated to be low average based on her responses and use of vocabulary. Memory is faulty. There are inconsistencies and inaccuracies and gaps with respect to her mental health issues and treatment during the course of her growing up years and later on in adulthood. Insight is partial at best and intellectual. Judgment is impaired. Failed to learn over the years from the consequences of her illegal activities. Continued to use poor judgment, acting impulsively. There is no evidence of any SI or HI. The AIMS test is negative.MENTAL STATUS EXAMINATION: General appearance was that of a (XX)-year-old female of average height and obese weight. Hygiene was within normal limits. General appearance was somewhat messy. The patient was alert and oriented x4, cooperating fully with the exam. Motor activity was within normal limits. Gait was not assessed. Speech was within normal limits for rate, articulation, verbosity, and coherence. There were no signs of impairment in attention, concentration or memory. Judgment and insight were poor or lacking. Thought and perceptual acuity were within normal limits. There were some signs during the exam of deficits in impulse control. The patient acknowledged anhedonia. Her affective range was skewed in the direction of dysphoria. She ranked her recent mood as a 2 on a scale from 0-10. She acknowledges suicidal ideation and admits to considering options, though she can articulate no specific plan at this time. The patient denies any history of cutting. Her responses to the Beck Hopelessness Scale produced a score of 8/20. Such persons have reduced hope for the future. Her responses to the Brief Reasons for Living Scale indicated that 6 of the 10 commonly given reasons for wanting to live are important to the patient to some degree. Despite the absence of a prior suicide attempt, the patient’s substance abuse combined with her current dysphoric mood and difficulties with impulse control make it difficult to rule out risk of harm to self.MENTAL STATUS EXAMINATION: Showed a (XX)-year-old Hispanic male who looked his stated age. He was cooperative. His speech was relevant and coherent. His affect was congruent to the content of thought, mildly blunted. Mood was okay. No thoughts of perceptual disorder noted at this time. The patient denied being homicidal and suicidal. He denied any panic attacks; however, the patient reports he had some panic attacks earlier, but it was situation based and is no longer suffering from it and has not experienced it for a while. He was alert and oriented. Insight was reasonable. Memory functioning was intact.MENTAL STATUS EXAMINATION: The patient is a (XX)-year-old man who looked his stated age. He was of an average height and build. He was calm and cooperative during the interview. The patient made good eye contact and there was no psychomotor agitation or retardation observed. His spe