



Client Name: _____

Date: _____

Insurance ID or SS#: _____

Medications: _____

CPT Code: _____

Type of Service: __ Individual __ Family __ Group

Date of Birth: _____

Symptoms: _____

MENTAL STATUS EXAM

Appearance Dress Appropriate Inappropriate Hygiene Good Fair Poor Eye Contact Appropriate Fair Poor

Manifest Behavior Cooperative Oppositional Passive Hostile Threatening Attention Seeking Guarded Agitated Fidgety
 Psychomotor Retardation Clearly Hyperactive Slowed Activity Tics Present Shy Intrusive Age Appropriate Restless

Speech Normal Rate Pressured Excessively Slowed Articulation Defect Fluent Normal Volume Soft Loud

Affect Full Range Anxious Depressed Labile Hostile Constricted Blunt Flat Inappropriate Appropriate

Mood _____ (Patient's Words), If applicable

Thought Processes Logical Circumstantial Tangential Goal-Directed Derailment Blocking

Unusual Thought Content Suicidal Ideation Homicidal Ideation Other _____ Not elicited

Perceptual Disturbances Auditory Visual Somatic Tactile Illusions Delusions Not elicited

Sleep Disturbances None Mild Moderate Severe Comments, if present _____

Eating Habits Normal Abnormal Severe problems Comments, if present _____

Attention Age-Appropriate Distractible **Concentration** Good Fair Severely Impaired **Insight/Judgment** Good Fair Poor

Other Reported Behavior: Home Good Fair Poor **School/Work** Good Fair Poor **Community** Good Fair Poor

Substance Usage: Current _____ **Past** _____

PROGRESS NOTE:

Interventions Used: _____

Homework: _____

Diagnosis: _____

GAF: _____

Counselor signature w/degree _____