Recipient Name: _____ Recipient I.D. No.: _____

I. **MENTAL STATES**

A. *GENERAL:*

1. Appearance: Within normal limits [ ] Other [ ] _____
2. Dress: Appropriate [ ] Bizarre [ ] Clean [ ] Dirty [ ]
3. Grooming: Neat [ ] Disheveled [ ] Needs Improvement [ ]

*B. BEHAVIOR:*

1. Eye Contact: Good [ ] Fair [ ] Poor [ ]
2. Posture: Good [ ] Slumped [ ] Rigid [ ] Other [ ] _____
3. Body Movement: None [ ] Involuntary [ ] Akathisia [ ] Other [ ] _____

C. *SPEECH:* Clear [ ] Mumbled [ ] Rapid [ ] Whispers [ ] Monotone [ ]
Slurred [ ] Slow [ ] Loud [ ] Constant [ ] Mute [ ]
Other [ ] _____

D. *MOOD:* Anxious [ ] Fearful [ ] Friendly [ ] Euphoric [ ] Calm [ ]
Aggressive [ ] Hostile [ ] Depressed [ ]
Other [ ] _____

E. *AFFECT:* Full Range [ ] Flat [ ] Constricted [ ] Inappropriate[ ]
Other [ ] _____

*F. THOUGHT:*

1. Process or Form: Loose associations [ ] Poverty of content [ ] Flight of ideas [ ]
Neologism [ ] Perseveration [ ] Blocking [ ]
2. Content: Delusions [ ] Thought broadcasting [ ]
Thought insertion [ ] Thought withdrawal [ ] Other [ ] _____

G. *PERCEPTION - HALLUCINATIONS:*

Auditory [ ] Tactile [ ] Somatic [ ] Other [ ] _____

*H. REALITY ORIENTATION:*

1. Mark all areas which the recipient can name:
Time: Day [ ] Month [ ] Year [ ]
Place: (can describe location) Yes [ ] No [ }
Person: Self [ ] Family or friend [ ]
2. Memory: Recent intact? Yes [ ] Remote intact? Yes [ ]
No [ ] No [ ]

I. *INSIGHT:* Aware of illness [ ] Denies illness [ ] Other [ ] _____

J. *JUDGMENT:* Good [ ] Fair [ ] Poor [ ]

Recipient Name: _____ Recipient I.D. No.: _____

II. **FUNCTIONAL SCALES:** *(check and specify any problem(s) in the following areas)*

[ ] Medical/Physical

_____

_____

[ ] Family/Living

_____

_____

[ ] Interpersonal Relations

_____

_____

[ ] Role Performance

_____

_____

[ ] Socio-Legal

_____

_____

[ ] Self-Care/Basic Needs

_____

_____

III. **ADDITIONAL COMMENTS**: Please supply any additional information which would be of assistance in reaching a decision with regard to this patient's evaluation.

Signed: _____ Date: _____

Reporting Psychiatrist/Psychologist *(Print Name):* _____

Reporting Psychiatrist/Psychologist Phone No.: _____