| CIP<br>Preparing Young Adults with Asperger's and LD for Success Since 1984<br>**MENTAL STATUS EXAMINATION REPORT** | Client:_____<br>Date of Birth:_____<br>Date of Report:_____ |
|---|---|

| **1. Identifying Information** |
|---|
| |
| |

| **2. Reason for Assessment** (Please indicate referral source, precipitating circumstances and chief complaints) |
|---|
| |
| |
| |

| **3. History of Presenting Problem** |
|---|
| |

## 4. Psychiatric History

### A. Psychiatric History (Include treatment modalities and facilities)

### B. Past Medications

### C. Current Psychotropic Medications

**Targeted Symptoms** (Circle all that apply; italics indicate symptoms found in multiple diagnosis)

| | | | | |
|---|---|---|---|---|
| **Depression** | **Depressed**<br>***Insomnia/*Hypersomnia**<br>**Feelings of worthlessness/Guilt**<br>**Crying spells** | **Anhedonia**<br>**Psychomotor *agitation*/retardation**<br>**Indecision/*Diminished concentration***<br>**Increased/decreased/appetite or weight** | | **Low libido**<br>**Energy loss**<br>**Suicidal Ideation** |
| **Hypo/Mania** | **Elevated/irritable mood**<br>**Hyperverbal Thought Racing** | **Grandiosity**<br>**Distractible** | **Excessive Risks**<br>***Hyperactive*** | ***Decreased need for sleep***<br>**Excessive Anger** **Hypersexuality** |
| **Anxiety** | **Anxiety/Somatic Symptoms**<br>**PTSD: Flashbacks** | **Panic Attacks**<br>**Avoidance** | **Phobic**<br>**Hyperarousal** | **Obsessions/Compulsions** |
| **Psychosis**<br>**ADHD** | **Delusions**<br>**Inattention** | **Hallucinations**<br>***Hyperactivity*** | **Disorganization**<br>**Impulsivity** | **Negative Symptoms** |

**Other (specify):**

## 5. Family Psychiatric History

## 6. Medical History

| | | |
|---|---|---|
| Cardiac | Yes | No |
| Liver | Yes | No |
| Renal | Yes | No |
| CNS | Yes | No |
| Other: | | |

### A. Current Medications for Medical Conditions



### B. Allergy Medications

| |
|---|
| |
| **7. History of physical/sexual abuse of self or others** (Please include prior treatment) |
| |
| |
| |
| |

| **8. History of Substance Abuse** (Please describe use, amount, frequency and past treatment programs) | | | | | |
|---|---|---|---|---|---|
| | **Recent (within 90 days)** | | **Past** | | **COMMENTS** |
| | **YES** | **NO** | **YES** | **NO** | |
| **Alcohol** | ☐ | ☐ | ☐ | ☐ | |
| **Sedatives** | ☐ | ☐ | ☐ | ☐ | |
| **Opiates** | ☐ | ☐ | ☐ | ☐ | |
| **Amphetamines** | ☐ | ☐ | ☐ | ☐ | |
| **Crack** | ☐ | ☐ | ☐ | ☐ | |
| **PCP Hallucinogens** | ☐ | ☐ | ☐ | ☐ | |
| **Marijuana** | ☐ | ☐ | ☐ | ☐ | |
| **Prescription Medication** | ☐ | ☐ | ☐ | ☐ | |

| **9. Suicidal Behavior** (Please address suicidal ideation, attempts, plans and describe) | | | | | |
|---|---|---|---|---|---|
| | **Recent (within 90 days)** | | **Past** | | **COMMENTS** |
| | **YES** | **NO** | **YES** | **NO** | |
| **Ideation** | ☐ | ☐ | ☐ | ☐ | |
| **Threat** | ☐ | ☐ | ☐ | ☐ | |
| **Plan** | ☐ | ☐ | ☐ | ☐ | |
| **Attempt** | ☐ | ☐ | ☐ | ☐ | |
| **Additional Comments:** | | | | | |

**10. Violent Behavior** (Please address violent behavior, describe with dates, if known, and explain if a weapon was used)

| | Recent (within 90 days) | | Past | | COMMENTS |
|---|---|---|---|---|---|
| | YES | NO | YES | NO | |
| **Assault on Person(s)** | ☐ | ☐ | ☐ | ☐ | |
| **Assault Attempt on Person(s)** | ☐ | ☐ | ☐ | ☐ | |
| **Ideation/Threat to Person(s)** | ☐ | ☐ | ☐ | ☐ | |
| **Assault Plan on Person(s)** | ☐ | ☐ | ☐ | ☐ | |
| **Property Damage** | ☐ | ☐ | ☐ | ☐ | |
| **Attempt to Damage Property** | ☐ | ☐ | ☐ | ☐ | |
| **Ideation/Threats to Damage Property** | ☐ | ☐ | ☐ | ☐ | |
| **Plan to Damage Property** | ☐ | ☐ | ☐ | ☐ | |
| **Possession of Weapons** | ☐ | ☐ | ☐ | ☐ | |

**Additional Comments:**

**11. Current Legal Issues and Criminal Justice History** (Please include conservatorship, guardianship, past and current incarcerations, probation, parole or pending court cases)

**12. Educational and Employment History**

**13. Current Support System/Family Strengths** (Please include family members and/or significant others)

**14. Client's Strengths and Resources**

| 15. Mental Status | | | | |
|---|---|---|---|---|
| **Appearance, Behavior and Speech** | | | | |
| **Movement Disorder** | ☐ NO | ☐ YES | (If YES, describe below): | |
| *Check all that apply and describe as indicated:* | | | | |
| **Suicidal Ideation** | ☐ YES | ☐ NO | | |
| **Homicidal Ideation** | ☐ YES | ☐ NO | | |
| **Mood:** | | | | |
| **Affect:** | | | | |
| **Orientation:** | | | | |
| *Thought Content (Check all that apply and describe as indicated)* | | | | |
| **Delusions** | ☐ YES | ☐ NO | **Content:** | |
| **Hallucinations** | ☐ YES | ☐ NO | ☐ Visual | ☐ Auditory |
| **Obsessions** | ☐ YES | ☐ NO | **Content:** | |
| *Thought Process (Check all that apply)* | | | | |
| ☐ Linear | ☐ Circumstantial | | ☐ Fragmented | |
| ☐ Tangential | ☐ Flight of Ideas | | **Other:** | |
| ☐ Loose | ☐ Associations | | | |
| *Abstract Reasoning (Check all that apply)* | | | | |
| ☐ Within Normal Limits | ☐ Impaired | | ☐ Impulse Control | |

| 16. Functional Limitation | Degree of Limitation | | | | | |
|---|---|---|---|---|---|---|
| **Restriction of activities of daily living** | None ☐ | Mild ☐ | Moderate ☐ | Marked ☐ | Extreme ☐ | Insufficient Evidence ☐ |
| **Difficulties in maintaining social functioning/relationships** | None ☐ | Mild ☐ | Moderate ☐ | Marked ☐ | Extreme ☐ | Insufficient Evidence ☐ |
| **Difficulties in maintaining concentration, persistence of place** | None ☐ | Mild ☐ | Moderate ☐ | Marked ☐ | Extreme ☐ | Insufficient Evidence ☐ |
| **Episodes of decomposition and increase of symptoms, each of extended duration** | None ☐ | Mild ☐ | Moderate ☐ | Marked ☐ | Extreme ☐ | Insufficient Evidence ☐ |

**Supporting Comments:**

| **17. Clinical Impression** | |
|---|---|
| | |
| | |
| | |
| **18. Diagnosis** | |
| **Axis I:** | **DSM-____CODE(S):** |
| **Axis II:** | **DSM-____CODE(S):** |
| **Axis III:** | |
| **Axis IV:** | |
| **Axis V: Current:** | **Past:** |

| **19. Service Necessity** (Justifies need for mental health services. Check all that apply and provide supporting comments) | |
|---|---|
| ☐ | **A. Daily Activities:** Client exhibits difficulties in education/employment/day/social activities. |
| ☐ | **B. Social Relationships:** Client does not have the ability to establish and maintain relationships, including social support systems. |
| ☐ | **C. Health:** Client is unable to maintain physical/mental hygiene and manage medications. |
| ☐ | **D. Symptoms:** Client exhibits repeated presence of psychotic symptoms or suicidal ideation/acts or violent ideation or acts to persons or property. |
| ☐ | **E. Psychiatric History:** Client has a psychiatric history of recurring substantial functional impairments and symptoms. The psychiatric history demonstrates that without mental health service there is a high risk of recurrence of functional level impairment. |
| **Supporting Comments:** | |

Completed by: _____
Signature

_____
Printed Name

_____ _____
Address Phone

**Please return to:** College Internship Program; National Admissions Office; 199 South Street, Pittsfield, MA 01201

admissions@cipworldwide.org; Fax: 413.445.5069