MENTAL STATUS EVALUATION

Name: ____ Age: ______________

Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Separated

☐ Divorced ☐ Widow

Prior Psychiatric treatment: ☐ No ☐ Yes, Explain: ______________________________

I. History of Present Illness: *For the following, please check, circle or complete all appropriate items.*

☐ Depressed or irritable mood
☐ Feelings of worthlessness or inappropriate quilt
☐ Impaired concentration or cognition
☐ Insomnia or hypersomnia
☐ Anxiety
☐ Lack of interest and motivation
☐ Substance Use: ☐ No ☐ Yes, Explain ______________________________
☐ Other: ______________________________

II. Family History: *(Please check, circle or complete all that apply).*

☐ Psychiatric Illness
☐ Suicide
☐ Depression
☐ Drugs and Alcohol
☐ Other: ______________________________

III. Mental Status Exam: *(Please check, circle or complete all that apply).*

☐ Well-developed	☐ Person	☐ In no apparent distress
Orientation:	☐ Normal	☐ Place ☐ Time
Speech:	☐ Euthymic	☐ Other __________
Mood:	☐ Normal range	☐ Other __________
Affect:	☐ Logical, Coherent, goal directed	☐ Other __________
Thought Process:	☐ No perceptual disturbances	☐ Other __________
Thought Content:	☐ Clear ☐ Cloudy	☐ Other __________
Sensorium:	☐ Intact ☐ Impaired	
Judgment:		

☐ After evaluating above described information, I hereby certify that ____________________ is able to work WITHOUT ANY KIND OF RESTRICTIONS.

☐ After evaluating above described information, I hereby recommend that ____________________ SHOULD BE EVALUATED BY A MENTAL HEALTH PROFESSIONAL, TO OBTAIN A THOROUGH PSYCHOLOGICAL EVALUATION.

______________________ ______________________ ____________
EVALUATING PHYSICIAN'S SIGNATURE DATE LIC.

______________________ ______________________
PRINT NAME PHONE

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