Emergency Department
Mental Health Assessment Form

☐ Medical Screening Exam completed PATIENT NAME_____

Indications for mental health assessment:

☐ Depression	☐ History of attempted suicide	☐ Drug overdose
☐ Feelings of hopelessness	☐ Suicidal Ideation	☐ Delusions
☐ Flat affect	☐ Manic status	☐ Altered Mental Status
☐ Documented inability to maintain nutrition or safety	☐ Self-mutilative actions	☐ Violence toward persons or property

Assessed by _____ Date _____ Time _____

BEHAVIOR

Posture:
☐ Normal
☐ Slumped
☐ Rigid
☐ Other _____

Gait:
☐ Normal
☐ Abnormal _____

Expression:
☐ Unremarkable
☐ Immobile
☐ Sad
☐ Worried
☐ Angry
☐ Variable
☐ Happy
☐ Other _____

Eye Contact:
☐ Good
☐ Avoided
☐ Stared into space
☐ Intense, fixed

Attention span:
☐ Satisfactory
☐ Distractible
☐ Poor

Motor Level:
☐ Normal
☐ Hypoactive
☐ Hyperactive

Mannerisms:
☐ None
☐ Posturing
☐ Pacing
☐ Tics
☐ Hand wringing
☐ Buccolingual-Masticatory
☐ Other _____

MOOD

☐ Relaxed
☐ Anxious
☐ Fearful
☐ Angry
☐ Agitated
☐ Shame
☐ Guilt
☐ Indifference
☐ Depressed

SPEECH

Amplitude:
☐ Normal
☐ Loud
☐ Soft
☐ Screaming
☐ Monotone

Quality:
☐ Normal
☐ Mute
☐ Answers only questions
☐ Poverty of speech
☐ Other _____

Speed:
☐ Normal
☐ Fast
☐ Slow
☐ Pressured
☐ Other _____

THOUGHT PROCESS

Association:
☐ Logical
☐ Coherent
☐ Tight
☐ Blocking
☐ Loose
☐ Incoherent
☐ Clang (rhyming)

Stream of thought:
☐ Unremarkable
☐ Over inclusive
☐ Concrete
☐ Echolatic
☐ Joking
☐ Flight of ideas
☐ Tangential
☐ Non-spontaneous
☐ Circumstantial
☐ Precise
☐ Other _____

THOUGHT CONTENT

Delusions:
☐ None
☐ Grandiose
☐ Perseculory
☐ Self-accusatory
☐ Somatic

Check if "yes"
☐ Feelings of influence
☐ Ideas of reference
☐ Depression
☐ Obsessions/Compulsions
☐ Phobic thoughts
☐ Anxieties
☐ Depersonalization
☐ Derealization
☐ Illusions
☐ Hallucinations

SENSORIUM AND REASONING

☐ Clear judgment
☐ Lacks judgment
☐ Can follow directions
☐ Patient understands why brought here
☐ Appropriate long/short term memory
☐ Impaired short tem memory
☐ Impaired long term memory

ACTIVITIES OF DAILY LIVING

☐ Independent
☐ Needs assistance
☐ Unable to perform

☐ SUICIDAL IDEATION

☐ SUICIDAL PLAN

☐ POTENTIALLY VIOLENT

PHYSICIAN SIGNATURE	DATE	TIME