

**GEORGIA DEPARTMENT OF CORRECTIONS**  
**MH/MR SERVICES**  
**MENTAL STATUS EVALUATION**

INSTITUTION: \_\_\_\_\_  
NAME: \_\_\_\_\_  
ID #: \_\_\_\_\_  
DOB: \_\_\_\_\_  
RACE: \_\_\_\_\_ SEX: \_\_\_\_\_

<p><b>1. DRESS</b> <input type="checkbox"/> Appropriate/clean clothes <input type="checkbox"/> Disheveled/soiled clothes <input type="checkbox"/> Inappropriate/non-clothes</p> <p><b>2. HYGIENE</b> <input type="checkbox"/> Good <input type="checkbox"/> Adequate <input type="checkbox"/> Poor</p> <p><b>3. APPEARANCE</b> <input type="checkbox"/> Meticulous <input type="checkbox"/> Appropriate <input type="checkbox"/> Unkempt</p> <p><b>4. FACIAL EXPRESSIONS</b> <input type="checkbox"/> Appropriate to verbal content <input type="checkbox"/> Inappropriate <input type="checkbox"/> Bizarre <input type="checkbox"/> Minimized <input type="checkbox"/> Fixed</p> <p><b>5. TONE OF VOICE</b> <input type="checkbox"/> Normal <input type="checkbox"/> Loud <input type="checkbox"/> Soft <input type="checkbox"/> Monotone</p> <p><b>6. RATE OF SPEECH</b> <input type="checkbox"/> Appropriate <input type="checkbox"/> Rapid <input type="checkbox"/> Slowed</p> <p><b>7. MANNER OF SPEECH</b> <input type="checkbox"/> Normal <input type="checkbox"/> Pressured <input type="checkbox"/> Hesitant <input type="checkbox"/> Stuttering <input type="checkbox"/> Slurred <input type="checkbox"/> Emotional</p> <p><b>8. SPEECH CONTENT</b> <input type="checkbox"/> No unusual aspects noted <input type="checkbox"/> Morbid <input type="checkbox"/> Perseverative <input type="checkbox"/> Ideas of reference <input type="checkbox"/> Excessive Somatization <input type="checkbox"/> Hyper-religiosity <input type="checkbox"/> Nonsensical <input type="checkbox"/> Electively Mute</p> <p><b>9. THOUGHT PROCESS</b> <input type="checkbox"/> Logical/Coherent <input type="checkbox"/> Illogical/Incoherent <input type="checkbox"/> Circumstantial <input type="checkbox"/> Tangential <input type="checkbox"/> Concrete <input type="checkbox"/> Blocking</p> <p><b>10. DELUSIONS APPARENT</b> <input type="checkbox"/> None <input type="checkbox"/> Persecutory <input type="checkbox"/> Self-deprecatory <input type="checkbox"/> Grandiose <input type="checkbox"/> Somatic</p>	<p><b>11. SELF-INJURY</b> <input type="checkbox"/> No thoughts of self-injury <input type="checkbox"/> Current thoughts of self-injury <input type="checkbox"/> Current plans for self-injury <input type="checkbox"/> Recent attempts or acts of self-injury <input type="checkbox"/> Past attempts or acts of self-injury <input type="checkbox"/> Occasional/passing thoughts of suicide <input type="checkbox"/> Preoccupying thoughts of suicide <input type="checkbox"/> Suicide plan <input type="checkbox"/> Recent suicide attempt <input type="checkbox"/> Past suicide attempt</p> <p><b>12. OTHER-INJURY IDEATION/BEHAVIOR</b> <input type="checkbox"/> No history of assaultive behavior <input type="checkbox"/> History of infrequent assaultive behavior <input type="checkbox"/> History of frequent assaultive behavior <input type="checkbox"/> Recent assault <input type="checkbox"/> Homicidal ideation <input type="checkbox"/> Homicide plan <input type="checkbox"/> Past homicide attempt <input type="checkbox"/> Recent homicide attempt <input type="checkbox"/> Past homicide <input type="checkbox"/> Recent homicide</p> <p><b>13. HALLUCINATIONS APPARENT</b> <input type="checkbox"/> None <input type="checkbox"/> Auditory <input type="checkbox"/> Visual <input type="checkbox"/> Tactile <input type="checkbox"/> Other</p> <p><b>14. MOOD</b> <input type="checkbox"/> Undetermined <input type="checkbox"/> Euthymic (normal) <input type="checkbox"/> Apathetic <input type="checkbox"/> Dysphoric (sad) <input type="checkbox"/> Anxious <input type="checkbox"/> Fearful <input type="checkbox"/> Suspicious <input type="checkbox"/> Irritable <input type="checkbox"/> Angry <input type="checkbox"/> Euphoric (elevated)</p> <p><b>15. AFFECT</b> <input type="checkbox"/> Appropriate to status <input type="checkbox"/> Broad <input type="checkbox"/> Exaggerated <input type="checkbox"/> Labile <input type="checkbox"/> Inappropriate <input type="checkbox"/> Restricted <input type="checkbox"/> Flattened</p> <p><b>16. SLEEP PATTERN</b> <input type="checkbox"/> Normal <input type="checkbox"/> Insomnia <input type="checkbox"/> Frequent waking <input type="checkbox"/> Decreased hours <input type="checkbox"/> Restlessness <input type="checkbox"/> Increased hours <input type="checkbox"/> Early morning waking <input type="checkbox"/> Nightmares</p>	<p><b>17. EATING BEHAVIOR</b> <input type="checkbox"/> No problem <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Increase in appetite <input type="checkbox"/> Fasting <input type="checkbox"/> Hunger strike <input type="checkbox"/> Vomiting <input type="checkbox"/> Rapid weight gain or loss</p> <p><b>18. ORIENTATION</b> <input type="checkbox"/> Time <input type="checkbox"/> Place <input type="checkbox"/> Person <input type="checkbox"/> Situation <input type="checkbox"/> Times four</p> <p><b>19. MEMORY</b> <input type="checkbox"/> No notable impairment <input type="checkbox"/> Impaired immediate recall <input type="checkbox"/> Impaired recent memory <input type="checkbox"/> Impaired remote memory</p> <p><b>20. ESTIMATED INTELLECTUAL LEVEL</b> <input type="checkbox"/> Above average <input type="checkbox"/> Average <input type="checkbox"/> Below average <input type="checkbox"/> Possible retardation</p> <p><b>21. JUDGMENT</b> <input type="checkbox"/> Above average <input type="checkbox"/> Average <input type="checkbox"/> Below average <input type="checkbox"/> Poor <input type="checkbox"/> Variable</p> <p><b>22. INSIGHT</b> <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <i>[ ] Extremely limited</i></p> <p><b>23. IMPULSE CONTROL</b> <input type="checkbox"/> Over-controlled <input type="checkbox"/> Average <input type="checkbox"/> Below average</p> <p><b>24. INTERACTION WITH EXAMINER</b> <input type="checkbox"/> Cooperative <input type="checkbox"/> Uncooperative <input type="checkbox"/> Domineering <input type="checkbox"/> Ingratiating <input type="checkbox"/> Manipulative <input type="checkbox"/> Dependent <input type="checkbox"/> Evasive <input type="checkbox"/> Defensive</p>
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Evaluator/Title

\_\_\_\_\_  
Date

\_\_\_\_\_  
Reviewer/Title

\_\_\_\_\_  
Date