Clinical Interview/Mental Status

For Use with the Franklin County ADAMH Expedited SSI/SSDI Program
To be used in conjunction with the Daily Activity Questionnaire
Please note items with an asterisk (*) are based on the evaluator's observation

Date of evaluation: _____ Time of evaluation: _____
Length of evaluation: _____

IDENTIFYING INFORMATION:

Name: _____ SSN: _____

DOB: _____ Age: _____

*Did the client have difficulty providing name, SSN, DOB or age? ☐ No ☐ Yes, describe problems. _____

Is the client with someone for support for the evaluation? ☐ No ☐ Yes, who? _____

Are you currently ☐Married ☐Divorced ☐Widowed ☐Separated ☐Single

If divorced, why did the marriage end? _____

EDUCATIONAL HISTORY:

How far did you get in primary school? _____
Did you ever have to repeat a grade? ☐ No ☐ Yes, why? _____

If you did not finish school, why not? _____

What kind of grades did you get in school? _____

Did you enjoy school? ☐ Yes ☐ No, Why not _____

Were you ever in special education classes? ☐ No ☐ Yes, Specify learning or behavior problems? _____
Was it all day special education classes or just certain classes (specify what classes)? _____
When did you begin special education classes? _____

If you did not graduate, do you have a GED? ☐ No ☐ Yes

Did you attend college? ☐ No ☐ Yes, what did you study, how many years did you attend and did you receive a degree? _____

PROBLEMS IN THE COMMUNITY:

How much contact do you have with your neighbors? _____

Do you have any problems getting along with your neighbors? ☐ No ☐ Yes, describe _____

Do you have any problems with people in authority? ☐ No ☐ Yes, describe _____

MENTAL HEALTH HISTORY:

Have you ever been involved in outpatient services? ☐ No ☐ Yes, when, how long, for what? _____ If currently attending, how often do you attend and for what services? _____

Have you ever been admitted overnight to the hospital for mental health problems? ☐ No ☐ Yes, for what conditions, when and how long did you stay in the hospital? _____

MENTAL STATUS:

Appearance and Behavior:

*Describe the client's appearance including descriptors such as neat, clean, odor, unkempt, dirty. Provide details of the odor (such as alcohol, urine, general body odor, etc.) and if dirty describe degree. _____

*Is the client dressed appropriately for the weather and situation? ☐ Yes ☐ No, describe problems _____

*Does the client understand the purpose of the evaluation? ☐ Yes ☐ No, describe problems _____

*Is the client cooperative? ☐ Yes ☐ No, describe problems _____

*Describe any eccentric behavior. _____

*Describe any impulsive behavior. _____

*Is eye contact good, inconsistent or poor? _____

*Are facial and gestural expressiveness minimal, normal or exaggerated? _____

*Is tone of voice monotone, normal or exaggerated? _____

*Describe posture. _____

*Describe any limitations noted in fine or gross motor abilities (such as walking with a limp, slow, etc.). _____

Flow of Conversation and Thought:

*Describe speech using descriptors such as fast, slow, confused, loud, soft, direct, insecure, stutter, list, slurring, etc. _____

*Describe problems related to:
Flight of ideas _____
Perseveration _____
Poverty of speech _____

*Describe quality of associations using descriptor such as loose, circumstantial, tangential and well organized.
_____

Affect and Mood:

*Was the client's affect: ☐reactive ☐constricted ☐blunted ☐flattened ☐exaggerated ☐inappropriate

*The client's prevailing mood appears: ☐euthymic ☐dysphoric ☐anxious ☐irritable ☐labile ☐angry

How do you feel today physically? _____

How do you feel today emotionally? _____

How is your appetite? _____

How many hours do you sleep per night? _____

Do you have trouble sleeping? ☐ No ☐ Yes, describe problems falling or staying asleep, waking too early or sleeping too much. _____

Do you nap during the day? ☐ No ☐ Yes, how often and how long? _____

Do you have times when you cry for no reason and cannot stop? ☐ No ☐ Yes, how often? _____

Do you ever get down or depressed? ☐ No ☐ Yes, how long has this been happening? _____

What kind of things make you depressed? _____

What actions do you take when you get depressed? _____

Do you ever think about hurting yourself now? (if yes, assess whether there is a current plan to determine if action is needed) ☐ No ☐ Yes, _____

Do you ever think about hurting someone else now? (if yes, assess whether there is a current plan to determine if action is needed) ☐ No ☐ Yes, _____

*Describe if there is evidence of psychomotor retardation or agitation. _____

Do you currently feel hopeless, helpless, full or guilt or worthless? ☐ No ☐ Yes, specify all that apply _____

How is your energy level? _____

Do you ever have times when you have so much energy you weren't tired and don't need to sleep for a few days? ☐ No ☐ Yes, how often and how long does it last? _____

During these periods without sleep, describe symptoms you experience (check all that apply):

☐euphoria	☐irritability	☐goal directed activity	☐impulsiveness
☐racing thoughts	☐excessive speech	☐pressured speech	☐pleasure seeking activity
☐grandiose thinking	☐suspiciousness	☐paranoia	☐hallucinations (describe): _____

Are there times you feel your mood is normal? ☐ No ☐ Yes, how often? _____

What are your best qualities? _____

What are your worst qualities? _____

Anxiety:

*Describe any outward signs of anxiety such as fidgeting, trembling, pacing, rigid posture, etc. _____

Do you get anxiety or nervous feelings? _____

What type of things seem to make you anxious or nervous? _____

What actions do you take when you feel anxious or nervous? _____

Do you have anxiety attacks or panic attacks? ☐ No ☐ Yes, how often, how long do they last and describe what symptoms you have during the attack. _____

Do you get irritated or angry easily? ☐ No ☐ Yes, what kinds of things make you angry? _____

Do you have any phobias or fears? ☐ No ☐ Yes, specify _____

Do you worry a lot? ☐ No ☐ Yes, about what? _____

Mental Content:

Do you ever hear voices or see things that are not there? ☐ No ☐ Yes, describe. _____

Do you ever feel you have special powers or abilities such as reading minds or predicting the future? ☐ No ☐ Yes, describe. _____

Do you ever get stuck on a single thought and can't stop? ☐ No ☐ Yes, describe. _____

Do you have any compulsive behaviors like washing your hands over and over again or checking on things? ☐ No ☐ Yes, describe. _____

SENSORIUM AND COGNITIVE FUNCTIONING:

*Describe the client's level of alertness using descriptors such as alert, oriented, fantasy, dissociative, confused. _____

Tell me the current date and day of the week. (note if the client was able to recite the current month, day, year and day of the week? _____

Digit Span:
Repeat the following numbers (you may skip column two if the client gets column one right and you may stop after client gets two in a row wrong)

5-8-2	_____	6-9-4	_____
6-4-3-9	_____	7-2-8-6	_____
4-2-7-3-1	_____	7-5-8-3-6	_____
6-1-9-4-7-3	_____	3-9-2-4-8-7	_____
5-9-1-7-4-2-8	_____	4-1-7-9-3-8-6	_____

Repeat the following numbers backward. For example, if I tell you 6-3, you will respond with 3-6. (you may skip column two if the client gets column one right and you may stop after client gets two in a row wrong)

2-4	_____	5-8	_____
6-2-9	_____	4-1-5	_____
3-2-7-9	_____	4-9-6-8	_____
1-5-2-8-6	_____	6-1-8-4-3	_____
5-3-9-4-1-8	_____	7-2-4-8-5-6	_____

Please do this subtraction out loud. Start at 100 and subtract 7 over and over (have the client to go all the way down to 2 or you may stop after the client makes numerous errors or can't go further. Note if the client responds slowly, uses fingers, etc.). Document responses here: _____

Describe how the following pair of items are alike:

Orange-Banana _____
Dog-Lion _____
Coat-Suit _____
Boat-Automobile _____
Eye-Ear _____
Table-Chair _____

What do these sayings mean?
"What goes around comes around" _____
"There's no use crying over spilled milk" _____
"The grass is always greener on the other side" _____

Who is the current president of the United States? _____

Who was president before him? _____

Why do we wash clothes? _____

What would you do if you found an envelope in the street that is sealed, addressed and has a new stamp on it? _____

Tell me two or three reasons why many foods need to be cooked. _____

*Describe the client's ability to concentrate during this evaluation. _____

*Describe the client's persistence on tasks during this evaluation. _____

*Describe the client's pace during this evaluation. _____

Do you feel if you had the resources you could live independently? ☐ Yes ☐ No, why not? _____

Do you feel you are able to make important decisions about your future? ☐ Yes ☐ No, why not? _____

Are you able to seek community resources on your own? ☐ Yes ☐ No, why not? _____

Are there any things in your life that have happened or changed in the last year that continue to bother you?
☐ No ☐ Yes, _____

*Does the client appear to have insight into his/her own mental health concerns? _____

Diagnostic Impression:

DSM-IV-TR or DSM-V Multiaxial Classification:

Axis I:	**Axis I:**

Axis II:	**Axis II:**
Axis III:	**Axis III:**
Axis IV:	**Axis IV:**
Axis V:	**Axis V:**

Summary and Conclusions:

Narrative summary of findings:

_____

Four (4) Work Related Mental Capabilities: Summarize and discuss the degree to which these findings will affect the claimant's ability to carry on the below four work-related mental activities. For each of the 4 areas below, please explain if the claimant is not limited or not impaired or mildly, moderately, markedly or extremely limited/impaired and the clinical reasoning for your conclusions.

1. The mental ability to understand and follow instructions: - Explain if the claimant is not limited or not impaired or mildly, moderately, markedly or extremely limited/impaired and the clinical reasoning for your conclusions.

_____

2. The mental ability to maintain attention to perform simple, repetitive tasks: - Explain if the claimant is not limited or not impaired or mildly, moderately, markedly or extremely limited/impaired and the clinical reasoning for your conclusions.

_____

3. The mental ability to relate to others, including fellow workers and supervisors: - Explain if the claimant is not limited or not impaired or mildly, moderately, markedly or extremely limited/impaired and the clinical reasoning for your conclusions.

_____

4. The mental ability to withstand the stress and pressures associated with day-to-day work activity:
Explain if the claimant is not limited or not impaired or mildly, moderately, markedly or extremely limited/impaired and the clinical reasoning for your conclusions.

_____

Print Name:	**Signature:**	
Discipline:		**Date:**

Print Name:	**Signature:**	
Discipline:		**Date:**

Print Name:	**Signature:**	
Discipline:		**Date:**