

Denver School of Nursing N420 2009 Clinical  
Psychiatric Mental Health Data Collection

Student's Name \_\_\_\_\_ Clinical Grp \_\_\_\_\_ Date \_\_\_\_\_

**I. Client Assessment**

A. Client's Last Initial \_\_\_\_\_ Client's Age \_\_\_\_\_ Client location/Room \_\_\_\_\_  
Admit date \_\_\_\_\_ Gender \_\_\_\_\_ Marital Status \_\_\_\_\_ Children \_\_\_\_\_  
Career: \_\_\_\_\_ Last worked \_\_\_\_\_ Education \_\_\_\_\_  
Cultural background \_\_\_\_\_ Primary language \_\_\_\_\_  
Spiritual Live-dev.path/Religion \_\_\_\_\_  
Legal status \_\_\_\_\_ Privledges \_\_\_\_\_ Precautions \_\_\_\_\_  
Living arrangements \_\_\_\_\_ ADLs \_\_\_\_\_  
Family/community supports \_\_\_\_\_  
Erikson's Development Stage \_\_\_\_\_

**B. DSM-IV Admitting Diagnosis:** \_\_\_\_\_

(See Varcarolis et al., p 8-11)

Axis I—(Clinical disorders) \_\_\_\_\_

Axis II—(Personality Disorders & MR) \_\_\_\_\_

Axis III—(Gen. Med.) \_\_\_\_\_

Axis IV—(Psychosocial/Environ.) \_\_\_\_\_

Axis V—(GAF # and behavior, Varcarolis et al., p.10) \_\_\_\_\_

**C. Psychopathology Causing Admission:** (Behavior, thought process, dysfunction, crisis event, and past history or mental illness or addictions)

**D. Contributing History or Events:** (i.e. social, cultural, or family event)

**E. Discharge Plan:**

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**II. Mental Status Exam Flow Sheet (Varcarolis et al., 2006, p. 141-142)**

**IDENTIFYING DATA**

Name (Initials only) _____	Living arrangements _____
Gender _____	Religious preference _____
Age _____	Allergies _____
Race/culture _____	Special diet _____
Occupational/financial status _____	Chief complaints _____
Significant Other _____	Medical Diagnosis _____

**GENERAL DESCRIPTION**

**Appearance**

Grooming/dress _____	Hair color/texture _____
Hygiene _____	Scar/tattoo/skin marks _____
Posture _____	Appearance compared to age _____
Height and weight _____	Level of eye contact _____

**Motor Activity**

Tremors _____	Rigidity _____
Tics or other stereotypical movements _____	Gait patterns _____
Mannerisms & gestures _____	Echopraxia _____
Restlessness or agitation _____	Psychomotor retardation _____
Aggressiveness _____	Freedom of movement(ROM) _____

**Speech Patterns**

Slowness or rapidity of speech _____	Volume _____
Pressure of speech _____	Stuttering/speech impairment _____
Intonation _____	Aphasia _____

**General Attitude**

Cooperative/uncooperative _____	Uninterested/apathetic _____
Friendly/hostile/defensive _____	Guarded/suspicious _____

**EMOTIONS**

**Mood**

Sad _____	Depressed _____	Despairing _____
Irritable _____	Anxious _____	Elated _____
Euphoric _____	Fearful _____	Guilty _____
Labile _____		

**Affect**

Congruence with mood  
 Constricted or blunted (diminished arousal/range and intensity of emotional expression)  
 Flat (absence of emotional expression)  
 Appropriate or inappropriate (defines congruence of affect with the situation or with the client's behavior)

**THOUGHT PROCESSES**

**Form of Thought**

Flight of ideas _____	Associative looseness _____
Circumstantiality _____	Tangentiality _____
Neologisms _____	Concrete thinking _____

Clang associations \_\_\_\_\_ Word salad \_\_\_\_\_  
 Perversion \_\_\_\_\_ Ability to concentrate \_\_\_\_\_  
 Echolalia \_\_\_\_\_ Mutism \_\_\_\_\_  
 Poverty of speech (restriction in the amount of speech) \_\_\_\_\_  
 Attention span \_\_\_\_\_

**Content of Thought**

## Delusions

Persecutory \_\_\_\_\_ Grandiose \_\_\_\_\_ Reference \_\_\_\_\_  
 Control or influence \_\_\_\_\_ Somatic \_\_\_\_\_ Nihilistic \_\_\_\_\_

Suicidal or homicidal ideas \_\_\_\_\_

Obsessions \_\_\_\_\_

Paranoia/suspiciousness \_\_\_\_\_

Magical thinking \_\_\_\_\_

Religiosity \_\_\_\_\_

Phobias \_\_\_\_\_

Poverty of content (vague, meaningless responses) \_\_\_\_\_

**PERCEPTUAL DISTURBANCES**

## Hallucinations

Auditory \_\_\_\_\_ Visual \_\_\_\_\_  
 Tactile \_\_\_\_\_ Olfactory \_\_\_\_\_ Gustatory \_\_\_\_\_

## Illusions

Depersonalization (altered perception of the self)

Derealization (altered perception of the environment)

**SENSORIUM AND COGNITIVE ABILITY**

Level of alertness/consciousness

## Orientation:

Time \_\_\_\_\_  
 Place \_\_\_\_\_  
 Person \_\_\_\_\_  
 Circumstances \_\_\_\_\_

## Memory:

Recent \_\_\_\_\_  
 Remote \_\_\_\_\_  
 Confabulation \_\_\_\_\_

Capacity for abstract thought \_\_\_\_\_

**IMPULSE CONTROL**

Ability to control impulses related to the following:

Aggression \_\_\_\_\_ Guilt \_\_\_\_\_  
 Hostility \_\_\_\_\_ Affection \_\_\_\_\_  
 Fear \_\_\_\_\_ Sexual feelings \_\_\_\_\_

**JUDGMENT AND INSIGHT**

Ability to solve problems

Ability to make decisions

Knowledge about self

Awareness of limitation  
 Awareness of consequences of actions  
 Awareness of illness

Adaptive/maladaptive use of coping strategies and ego defense mechanisms

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**Documentation/ Charting**

It is important that you as a nurse document in the chart what transpired during your time with the client/patient. This is not possible for you as a student in some clinical facilities to do so. However, you do need to practice documentation in the psych mental health setting. Since some psych patient's records may be reviewed in court to determine whether or not a patient will be committed or other legal processes taken, it is important you document in quotes what the patient said rather than write it in your own words. Be accurate and descriptive, but concise. Look for the patient's problem list or patient goals as created by the nursing staff in the facility you are having your psych clinical rotation. Select one of these patient problems or goals and write your documentation of your interaction with the patient in the **SOAPIE** format (Varcarolis, Carson, & Shoemaker, 2006, p. 131-132, 150-151).

Patient problem/goal:

S: (with subjective patient quotes)

O: (your observations)

A: (assessment/analysis or what you think is the problem or nursing diagnosis)

P: (plan must be consistent with the facility's stated plan)

I: (implemented or what you did)

E: (evaluation or client outcome)

**III. Medication Assessment Sheets ALLERGIES:**

**Scheduled Psychiatric Medications:**

Drug/Trade	Dose	Classification	Desired Response	Undesired Response	Nsg Implications	Labs	Mechanism of Action

**Scheduled non-psych meds/dose/action:**

**PRN Psychiatric Medications:**

Drug/Trade	Dose	Classification	Desired Response	Undesired Response	Nsg Implications	Labs	Mechanism of Action

**PRN non-psych meds/dose/action:**

**IV. Care Plan** **IMPORTANT:** Use NANDA nursing diagnoses. Patient goals must be measurable with a time frame (SMART) and if possible, the patient is part of this decision process. Write at least two nursing interventions for every patient goal. **ADA psych nursing standards categories you can implement are: counseling, milieu therapy, promotion of self-care (ADLs), psychobiological interventions, health teaching, and health promotion and maintenance.** Utilize at least two different psych nursing intervention categories in this care plan. (At least one nursing intervention must involve health teaching during your clinical experience—in the second week). Reference all intervention plans from text or other source and give a page number. Describe how you actually implemented the plan. Evaluate patient progress toward goal and effectiveness of nursing interventions. Analyze, revise.

**Problem (Not Nursing Diagnosis)**

Data (S) (O)	Nsg. Diag. (A)	Pt. Goal (P)	Nsg. Intervention Plan (P)	Implemented (I)	Evaluate (E)
I. Subjective (Patient)	1.	1.	1.Nsg.Intervention (Referenced*) (psych nsg category: _____) (Varcariolis et al., p.66,148-149)		Pt. Progress: Goal met?  1.Nsg.Interv. Effective?
II. Objective(Chart, Staff, Observations)	NANDA, Var. et al.,p.145,780	SMART?	2.Nsg. Intervention(Referenced*) (psych nsg category: _____)		2.Nsg Interv. Effective?

\*1. Reference source with page #:

\*2. Reference source with page #:

Analyze, evaluate, and **revise** the nursing intervention plan. If you were to work with this patient again, what other nursing interventions might you try? Give a rationale and the reference (text and page number) for the “new” nursing intervention.

\*Describe how at least three different non-nursing multidiscipline team members contributed in the team process of partnering with the patient toward achieving increased mental health. (Such team members may be occupational therapy (OT), recreational therapy (RT), social work (SW), dietitian, physician, psychiatrist, psychologist, or law enforcement).

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- 1.
  - 2.
  - 3.
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# ABNORMAL INVOLUNTARY MOVEMENT SCALE (AIMS)

(Reference tag: F222; Cross reference tags: F329 - F331)

**INSTRUCTIONS:** Complete examination procedure before making ratings. While conducting the examination, have resident sit in a firm chair without arms. For all MOVEMENT ratings (sections A, B and C) rate highest severity observed. Circle only one code for each evaluation.

**SCORING CODES:** 0 = None      1 = Minimal/Normal      2 = Mild      3 = Moderate      4 = Severe

SECTION A. FACIAL AND ORAL MOVEMENTS		ASSESSMENT DATES			
1.	<b>MUSCLES OF FACIAL EXPRESSION</b> e.g., movements of forehead, eyebrows, periorbital area, cheeks; include frowning, blinking, smiling, grimacing	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
2.	<b>LIPS AND PERIORAL AREA</b> e.g., puckering, pouting, smacking	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
3.	<b>JAW</b> e.g., biting, clenching, chewing, mouth opening, lateral movement	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
4.	<b>TONGUE</b> Rate only increase in movement both in and out of mouth, NOT inability to sustain movement.	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
SECTION B. EXTREMITY MOVEMENTS					
5.	<b>UPPER (ARMS, WRISTS, HANDS, FINGERS)</b> Include choreic movements, (i.e., rapid, objectively purposeless, irregular, spontaneous), athetoid movements (i.e., slow, irregular, complex, serpentine). Do NOT include tremor (i.e., repetitive, regular, rhythmic)	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
6.	<b>LOWER (LEGS, KNEES, ANKLES, TOES)</b> e.g., lateral knee movement, foot tapping, heel dropping, foot squirming, inversion and eversion of foot	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
SECTION C. TRUNK MOVEMENTS					
7.	<b>NECK, SHOULDERS, HIPS</b> e.g., rocking, twisting, squirming, pelvic gyrations	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
SECTION D. GLOBAL JUDGMENTS					
8.	<b>SEVERITY OF ABNORMAL MOVEMENTS</b>	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
9.	<b>INCAPACITATION DUE TO ABNORMAL MOVEMENTS</b>	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
10.	<b>RESIDENT AWARENESS OF ABNORMAL MOVEMENTS</b> Rate only patient's report	0= No awareness 1= Aware, no distress 2= Aware, mild distress 3= Aware, moderate distress 4= Aware, severe distress	0= No awareness 1= Aware, no distress 2= Aware, mild distress 3= Aware, moderate distress 4= Aware, severe distress	0= No awareness 1= Aware, no distress 2= Aware, mild distress 3= Aware, moderate distress 4= Aware, severe distress	0= No awareness 1= Aware, no distress 2= Aware, mild distress 3= Aware, moderate distress 4= Aware, severe distress
SECTION E. DENTAL STATUS					
11.	<b>CURRENT PROBLEMS WITH TEETH AND/OR DENTURES</b>	0= No 1= Yes	0= No 1= Yes	0= No 1= Yes	0= No 1= Yes
12.	<b>DOES RESIDENT USUALLY WEAR DENTURES?</b>	0= No 1= Yes	0= No 1= Yes	0= No 1= Yes	0= No 1= Yes
EVALUATOR SIGNATURES					
Signature/Title _____		Date _____	Signature/Title _____		Date _____
Signature/Title _____		Date _____	Signature/Title _____		Date _____
NAME—Last		First	Middle	Attending Physician	
				Chart No. _____	

## INSTRUCTIONS FOR CONDUCTING THE RESIDENT EXAMINATION

Complete examination procedures before making actual movement ratings. The chair to be used in this examination should be firm and without arms.

### A. FACIAL AND ORAL MOVEMENTS

- Ask resident to open mouth. Observe tongue at rest within mouth. Do this twice.
- Ask resident to protrude tongue. Observe abnormalities of tongue movement.

### B. EXTREMITY MOVEMENTS

- Flex and extend resident's left and right arms, one at a time. Note any rigidity.
- Ask resident to extend both arms outstretched in front with palms down. Observe trunk, legs, and mouth.
- Have resident walk a few paces, turn, and walk back to chair. Observe hands and gait. Do this twice.
- Ask resident to tap thumb with each finger as rapidly as possible for 10 - 15 seconds with both left and right hand. Observe facial and leg movements.

### C. TRUNK MOVEMENTS

- Ask resident to stand up. Observe in profile all body areas.
- Have resident sit in chair with hands on knees, legs slightly apart, and feet flat on floor. Observe entire body for movements.
- Ask resident to sit with hands hanging unsupported. If male, between knees or if female in dress, hanging over knees. Observe hands and other body areas.

### D. GLOBAL JUDGMENTS

- Ask resident if he/she notices any movement in mouth, face, hands, or feet. If YES, ask to what extent they currently interfere with activities.

### E. DENTAL STATUS

- Remove any material from mouth.
- Ask resident about current condition of teeth, i.e., partial, dentures. Do either bother resident now?

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#### Interpretation of AIMS score:

0-1 = LOW RISK OF MOVEMENT DISORDER

2 in only one of seven body areas = BORDERLINE, OBSERVE CLOSELY

2 in two or more of seven body areas = REFERRAL FOR COMPLETE NEUROLOGICAL EXAM

3 or 4 in only one body area = REFERRAL FOR COMPLETE NEUROLOGICAL EXAM

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**SIGN AND DATE THE COMPLETED AIMS FORM.  
FILE IN THE RESIDENTS CHART.**

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