Adult Comprehensive Assessment

The Adult Comprehensive Assessment provides a standard format to assess mental health, substance use, and functional needs of individuals served. This Assessment provides a summary of assessed needs that serve as the basis of Goals and Objectives in the Individualized Action Plan.

Data Field	Identifying Information
Organization and Program Name	Record the names of the Organization and the Program if applicable
Individual's Name	Record the first name, last name, and middle initial of the Individual being served. Order of name is at agency discretion.
Record #	Record your agency's established Record number for the Individual.
Date of Birth	Record the date of birth of the Individual. **(e.g. MM/DD/YYYY)**
Data Field	**Presenting Concerns**
Reason for Referral	Document the reason the individual was referred for services in individual's or referent's own words. Record troublesome symptoms, behaviors and/or problems affecting day-to-day functioning, relationships, and work, as reported by the individual served. **Examples: If the occurrence was losing a job, factors would include: "Feeling like I have no energy at work, snapping at my boss and co-workers, and coming in late due to not being able to get up in the morning." If the occurrence was hospitalized due to feeling suicidal, factors would include: "Suicidal feelings have been that way for 5 days, broke up with my abusive boyfriend two weeks ago, have cut self in past, and I was drinking when I cut myself this time."**
Data Field	**Living Situation**
Where is the Individual Currently Living	Check the box (or boxes) to indicate what the individual's current living situation is. You are not required to check off one box under each category (i.e., individual's home, residential care/treatment facility, other).
Residential Care/Treatment Facility	Check if individual served is in one of these living situations.
At Risk of Losing Current Housing	Check *Yes* or *No*. If yes, provide comments that illustrate the situation.
Satisfied with Current Living Situation	Check *Yes* or *No*. If No, provide comments that illustrate the situation.
Household	Describe household composition including persons living with individual other than their children
Family Information	Does individual have children? If Yes, identify them by name. Complete the grid with the name of each child, age, and the individual with whom the child is living. Note any custody issues, i.e. foster care. If No, skip to next section.
Family History and Relationships	Record details of what the individual/guardian/parent and the interviewer identify as important facts regarding the individual's family history and family relationships. **Examples: Sarah is very close with her mother and father. Frank is not on speaking terms with his brothers and sisters. Family moved 12 times in twelve years. Children placed in foster care when younger. Maria migrated to the U.S. at age seven.**
Pertinent Family Medical, Mental Health and Substance Abuse History	Include any identified family history of medical, psychiatric, or substance use disorders including Adult Child of Alcoholic (ACOA) and Child of Substance Abuser (COSA) status. **Example: Mother treated for depression. Family history of heart disease and diabetes.**

Data Field	Developmental History
Developmental History	Record specific and pertinent developmental history you think may have an impact upon the current functioning of the individual and its effect on the treatments and supports likely to be employed. Include speech/language, sensory/motor, and cognitive deficits. Be sure to include any head injuries. **Examples: Mother's use of alcohol while pregnant resulted in Fetal Alcohol Syndrome. Failure to thrive conditions of child after birth resulted in cognitive deficits. Diseases related to physical development. Family genetic history that affects the individual served. Injuries to the individual served during childhood that led to cognitive difficulties. Individual sustained multiple concussions during childhood as result of physical abuse and now suffers the effects of brain damage.**
Has individual been previously diagnosed with a developmental disability?	If yes, specify the disability and how it impacts the individual's needs and the family. Also indicate cause(s) if know.
Data Field	**Sexual History/Concerns**
Sexual History/Concerns	Record pertinent sexual history information identified by the individual, parent/guardian, or interviewer. Address topics such as concerns/questions about sexual orientation or gender identity; age of first sexual encounter; number and history of sexual partners; other behavior interviewer may consider relevant.
Data Field	**Social Supports**
Friendship/Social/Peer Support Relationships	Describe the individual's relationships with friends and other sources of social support. Describe social skills and limitations including difficulties the individual may experience in his/her relationships with others.
Meaningful Activities	Record the types of activities the individual participates in on a regular basis. Meaningful means the individual finds value and importance in the activity. Meaningful activity is determined by the individual, but it is up to the interviewer to explore how the individual is or has been involved in any volunteer, work, educational or other activities. In addition, record recreational outlets used by the individual. **Examples: Brian does the grocery shopping for his mom. Shikera works part time at a local nursing home as a housekeeper. Mohammed meets a group of friends every morning for coffee. Duc and best friend go out to movies every Friday. Agnes goes to church every Sunday and assists with Sunday school.**
Community Supports/Self-Help Groups	Record the supports the individual currently receives from his/her community or from self-help groups. Include a description of the support(s) being received. **Example: Youth Services, Visiting Nurses Association, Meals on Wheels, Church, social, or support groups, Drop in center involvement, Self-help groups such as Peer Support, Overeaters Anonymous, AA, NA, Sex Addicts Anonymous, Double Trouble.**

Religion/Spirituality	Record religious and/or spiritual issues important to the individual and that may impact his/her mental health and/or substance use treatment and support needs. Spirituality may encompass belief in a "higher power" or connection to some other entity that helps him/her feel a sense of significance, peace, or belonging without religious rituals. **Example: Sam reports prayer helps him cope with stress and adversity. Example of types of Religion: Catholic, Protestant, Jewish, Muslim, Wiccan, Jehovah's Witnesses, Buddhist. Example Spirituality: Juan's values and beliefs are not connected to an organized religion but he enjoys feeling connected to the natural environment.**
Cultural/Ethnic Information	Record cultural and ethnic issues considered important to the individual and/or family and are pertinent to mental health and/or substance use treatment and support needs. Identify issues in order to provide culturally competent treatment and support to the individual. Also, note any relevant issues relating to immigrant status and/or assimilation into American culture. **Examples: Family does not know that Jim is seeking help; he believes they would be non-supportive because in his ethnic community no one seeks help outside of the family. Ting states that her family is very close and that she expects they will be very supportive. Sarah strongly identifies as a Latino and is closely affiliated with the Latino community in her neighborhood.**
Race	Indicate the appropriate race by checking the indicators provided or indicate "unknown" if not able to determine race.
Data Field	**Legal Status**
Does individual served have a Legal Guardian, Rep Payee, or Conservatorship?	Check the appropriate box. If *yes*, complete the Legal Status Addendum.
Is there a need for a Legal Guardian, Rep Payee, or Conservatorship? Explain.	Check the appropriate box. If *yes,* provide details.
Data Field	**Legal Involvement History**
Does the individual have a history of, or current involvement with the legal system?	Check the appropriate box. If *yes*, complete the Legal Involvement and History Addendum
Data Field	**Education and Employment**
Education History	Check all boxes, and supply additional information, if indicated, that relates to individual's educational history.
Comments	Describe any pertinent information that has impacted individual's education. **Example: Pat dropped out of high school due to her substance abuse difficulties.**
Employment Status	Check all boxes that apply. If currently employed, indicate type of job, length of employment, and average number of hours worked.
Employment History	Provide relevant detail regarding Individual's employment history (type of job, how long past job held, and reason for leaving).
If not currently employed	Check appropriate box.
Does the individual want to work?	Check either No, Yes, or Uncertain/comments. Provide comments as appropriate.

Does the individual want help to find employment and/or further their education/training?	Check the appropriate box. If *yes*, complete the Employment/Education Addendum.
Data Field	**Military Service**
None Reported	If individual reports no military service history, check None Reported and skip to next section.
Military Service	Check the appropriate box. If "Yes" for individual or significant other/family member complete Military Service Addendum or the Military Service Addendum for Family/Significant Other at a later scheduled appointment. This additional assessment is a tool to guide you in your interventions and treatment planning. It should be broken down into several appointments, as it gathers an extensive amount of useful information.
Data Field	**Substance Use/Addictive Behavior History**
None reported	If individual does not report a Substance Use/ Addictive history, check None Reported and skip to next section.
Does individual report a history of, or current substance use/addictive behavior concerns?	If *"Yes"* to any current use, or history of any use, complete the Substance Use/Addictive Behavior History Addendum. Clinician must use their clinical judgment in determining whether or not the addendum is necessary for normal prescription drug use or over the counter drug use.
Data Field	**Mental Health and Addiction Treatment Service History (Inpatient/Outpatient)**
None Reported	If None Reported check box and skip to next section.
Type of Services	Record the type of service received in the past five (5) years; be as specific as possible. **Examples: Inpatient psychiatric hospitalization, inpatient detoxification and/or rehabilitation program, mental health clinic, partial hospitalization program, outpatient addictive recovery program.**
Dates of Service	Record the actual or approximate date range of service.
Reason	Record the reason that individual received treatment. **Example: Suicidal ideation; cocaine dependence**
Name of Provider / Agency	Record the name of the provider and/or agency.
Inpatient/Outpatient	Check box to indicate whether treatment course was inpatient or outpatient.
Completed	Check if individual completed the originally planned service. **Example: Check *No* if individual did not complete the full course of treatment.**
Age at time of initially seeking Outpatient Treatment Services	Indicate age that individual initially engaged in Outpatient Treatment Services (Mental Health and/or Addictive Recovery).
Total Number of Lifetime Outpatient Treatment Experiences	Indicate total number of discrete outpatient treatment experiences (episodes) for both Mental Health and Addictive Recovery services, over individual's lifetime.
Age at time of initially seeking Inpatient Treatment Services	Indicate age of individual's first inpatient treatment experience (Mental Health and/or Addictive Recovery).
Total Number of Lifetime Inpatient Treatment Experiences	Indicate total number of discrete inpatient treatment experiences for both Mental Health and Addictive Recovery services, over the individual's lifetime.

ER/Detox/Non-Detox-N/A	If no emergency room visits or detoxification experiences, check "N/A" box. Indicate total number of ER visits over the past six months. Provide number of days, if relevant, and whether hospital stay was due to medical or psychiatric reasons.
What was helpful with past treatment?	Indicate if treatment was helpful and explain why the individual thinks it was or was not helpful.
Comments	Provide any additional relevant comments regarding the individual's outpatient treatment history.
Data Field	**Psychiatric Illness History**
Psychiatric Illness History	Describe psychiatric illness history, from the age of onset.
Data Field	**Medication Information** (Include All Non-Psych Meds/Prescription/OTC, Herbal)
Medication	Record current psychiatric and non-psychiatric medications prescribed by a licensed prescriber, or self-prescribed, as well as over the counter and/or herbal medications and supplements. The information should be captured even if the individual does not know the name of the medication. If this is the case, in the Medication column list "unknown" and then list all other information the individual remembers.
None Reported	If None Reported, skip to the next question.
Dosage / Route / Frequency	Record the dosage, route, and frequency for each medication taken by the individual. It is suggested that dosage be recorded as unit/time of day. **Example: 50 mg by mouth @ 8 AM, 3 PM and 10 PM.**
Reported Side-effects	Record any reported side-effects the individual experiences.
Adherence	Check the box that best indicates if the individual takes the medication as prescribed or suggested.
Prescriber	Record the name of the physician or other licensed prescriber who prescribed the listed medication, if applicable.
Comments on Past Medications	Note which medications have been tried in the past indicating which ones have worked well or not. Record relevant comments, including reasons for discontinuation of the medication, why the individual doesn't take meds as prescribed, side-effects and any specific medications the individual would like to avoid taking in the future.
Data Field	**Trauma History**
Does individual report a history of, or current experience of trauma?	If there is no report of past or current trauma, check *None Reported*. If there is a report of past or current trauma, check the appropriate box and provide relevant details.

Data Field	Mental Status Evaluation (Or Refer to Attached Mental Status Evaluation)
Mental Status Examination	If completing Mental Status Evaluation Addendum, check the box on top, Refer to Attached Mental Status Evaluation. If not completing the addendum, provide a thorough written narrative below and answer the current risk related questions. Consider the following: • Avoid judgmental perceptions. • Take into account cultural differences. • Think of creating a picture of the individual served so that anyone reading the results of the exam would be able to clearly perceive the individual just as you do. Assessment items are "in the moment"; in other words, as the individual presents to you at the present time. There are other sections of the assessment form that address historical information.
Current Risk of Harm to Self	No- Individual denies any current risk to harm self. Yes- Individual communicates current risk to harm self. Comment-Provide relevant detail regarding current risk of harming self.
Current Risk of Harm to Others	No- Individual denies any current risk to harm others. Yes- Individual communicates current risk to harm others. Comment-Provide relevant detail regarding current risk of harming others. If individual did not report any Danger To Self/Others, check the box. If any of the current risk related questions are checked, complete and attach the Risk Assessment Addendum.
Data Field	**Past Risk and Alerts**
Past Attempt to Harm Self or Others	None reported-Individual does not report any past attempts to harm self/others. Self- Individual reports past attempt to harm self. Other- Individual reports past attempt to harm others. If individual has a history of harm to self/others, complete Risk Assessment Addendum.
History of non-suicidal/self-injurious behavior	No-Individual denies history of non-suicidal/self-injurious behavior Yes-Individual endorses history of non-suicidal/self-injurious behavior (describe such history in detail).
Significant losses within last two years, or experience of anniversary reaction to losses over lifetime	Check appropriate box. If Yes, describe in detail the specific losses endured and/or the anniversary reactions to losses that have occurred over an individual's lifetime. **Example; A parent's recurrent suicidal thoughts on the anniversary of his child's death.**
Imminent Stressors	Check appropriate box. If Yes, describe in detail and provide dates, if known. **Example: John has an imminent court date which could result in a lengthy prison sentence.**
Does individual have current or past difficulties with anger management?	If yes, describe (i.e., road rage, verbal explosiveness, physically assaultive).
Has individual ever been destructive to property?	If yes, indicate most recent date.

Has individual ever been violent toward persons?	If yes, indicate most recent date and answer the following: • Who was the violence directed toward? • Did violence result in injury? If yes, describe nature of the injury. • Did violence ever involve the use of a weapon? If yes, specify.
Data Field	**Assessed Needs Checklist Including Functional Domains**
CN and NI	For each item check whether it is Current Need (CN) or Not Clinically Indicated at this time (NI).
Current Need Areas	Current Need Areas will be based on the assessment. Check all current need areas for the individual. Each Current Need addressed will be used to develop "Identified Needs and Service Recommendations" later in the assessment that tie directly to the Individualized Action Plan and constitute the beginning of the order for treatment. Current Need should be determined based on assessment areas above with emphasis on those areas that interfere with or prevent assumption or continuation of the individual's self-determined valued life roles in the areas of Activities of Daily Living, Addictive Behaviors, Behavior Management, Family and Social Support, Mental Health/ Illness Management, Physical Health, Risk/Safety and Other.
As Evidenced by	Indicate the behavioral and other evidence, based on the assessments completed above, that support listing the area as an assessed need area.
Individual Served Desires Change Now?	Check the box that applies. This section will be used to generate the Prioritized Assessed Needs later in the assessment.
Data Field	**Screening Tools**
Were any screening tools, for either mental health or substance use, utilized?	Specify if any screening tools were utilized to help assess the Individual's functioning. For example, as a result of efforts by both OASAS and OMH, various screening tools have been identified to help identify co-morbidities (e.g. substance use/mental health) and support the goal of integrated treatment. Recommended tools for mental health screening include: Modified Mini Screen (MMS); Mental Health Screening Form III (MHSF-III); and K-6 (Kessler). Recommended tools for substance use screening include: Modified Simple Screening Instrument for Substance Abuse (MSSI-SA); CAGE-AID; and ASSIST. Other tools can be utilized as per agency's policy/direction.
Data Field	**Individuals Served Strengths/Abilities and Barriers** (Skills, Talents, Interests, Aspirations, Protective Factors)
Life Goals	Describe individual's life goals, in his/her own words. **Examples**: **Robert would like to move out of his parent's home and live on his own. Jessica would like to return to school and get a job. Wanda would like to regain custody of her children.**

Strengths	Describe skills, talents, interests, aspirations and protective factors that could be put into service toward achievement of the individual's goals. **Examples: Sense of humor, intelligence, determination, self-knowledge, strong family ties, community involvement, steady employment, persistence.**
Barriers to care and existing service gaps	Identification of the barriers due to the individual's mental illness or substance use that are preventing the achievement of the individual's recovery goals. Barriers can be practical (not being insured, limited time and competing priorities, transportation problems), psychological (perceived stigma), cultural, or other.
Past and Present Successes	Indicate past and present successes in achieving desired life goals, (e.g., obtaining a job, graduating from technical school, etc.)
Data Field	**Service Preferences**
Service Preferences	It is important that the clinician engage in a meaningful recovery focused dialogue with the individual (and/or primary support individual) which allows the individual (and/or primary support individual) to express his/her desired treatment, support preferences and priorities. Record the prioritized service preferences for the full range of behavioral health and community-based rehabilitative services, and environmental support services available, as identified by the individual (and others involved with the individual) based on the areas covered in the Assessed Needs. Include the individual's preferences to develop or have available additional natural and community supports, as a part of his/her Recovery Process. If applicable to the individual, discuss peer support, family education, other support, housing, transportation, social opportunities, and community involvement. Identify available resources. Discuss the individual's preferences for activities focused on reducing prejudice and discrimination against him/her and/or increasing his/her power and control over his/her life and future.
Data Field	**Clinical Formulation - Interpretive Summary**
This Clinical Summary is Based Upon Information Provided By	Check the box(s) that apply. Specify name of individual providing information and relationship to individual served. Indicate how information was obtained (i.e., by phone or in-person).
Interpretive Summary	Do not duplicate the information provided earlier in this document. Instead, provide a brief narrative summary and analysis that blends the findings and opinions of the interviewer(s) and the preferences of the individual/family into a concise synthesis. Describe the origin of the presenting problem(s), severity and factors contributing to its continuation, where the problem occurs (home, work, in community) and whether it is short or long term. Describe the significance of the problem(s) in the individual's cultural and developmental context. Summarize the individual's motivation for treatment and support, readiness for change, and potential barriers to change. Finally, assess individual's strengths and assets in the areas of individual qualities, daily living situation, financial assets and insurance coverage, work and education, social support, recreation/leisure skills, and spirituality/religion that can be leveraged to make progress toward the individual's goals.

Data Field	Diagnosis
General Instructions: Diagnosis	This section is used to record all current diagnoses that will provide the documented support for the medical necessity of services that will be provided for the individual. Diagnoses can be recorded in either ICD CM codes and narrative, or DSM codes and narrative. Check the applicable box at the top of the *Diagnosis* section to indicate if you are using ICD or DSM codes. **ICD CM Codes:** List codes in appropriate order using ICD coding conventions. Next to each code, complete a narrative description of the code from the ICD CM code book. Place a check next to the diagnosis that is the primary diagnosis for this treatment episode. **DSM Diagnostic Codes**: List codes next to appropriate Axis designation using DSM coding conventions. All five axes can be recorded in this section. Next to each code, complete a narrative description from the DSM code book. Place a check next to the diagnosis that is the primary diagnosis for this treatment episode.
Check Primary	Check the primary diagnosis.
Axis I Code	Indicate the ICD or DSM numerical or alphanumerical code.
Axis II Code	Indicate the ICD or DSM numerical or alphanumerical code.
Axis III Code	Indicate the ICD code(s) for selected general medical conditions.
Narrative	Provide narrative description of the diagnosis provided.
Axis IV	Check appropriate box related to specific psychosocial and environmental problems.
Axis V	Provide the Current GAF and Highest GAF in Past Year (if known). The GAF score is a rating from 1 to 100. The GAF scale is to be rated with respect only to psychological, social and occupational functioning.
Data Field	**Further Evaluations Needed**
Further Evaluations Needed	Check the box(es) that identify additional assessment(s) needed for the individual (if any).

Data Field	Prioritized Assessed Needs
Prioritized Assessed Needs	The information for this section comes from the overall assessment and in particular the Assessed Needs Checklist. Identify and record *Assessed Needs* of the individual. Assessed needs are not services or interventions but distressing symptoms, maladaptive behaviors, functional deficits, support deficits, etc. that prevent the individual from assuming desired life roles. To the right of each identified need check the appropriate box indicating whether the need is "Active" (i.e. will be addressed in the IAP), "Person Declined" (i.e. the individual chooses not to address this need at this time), "Deferred" (i.e. the Individual and clinician have determined not to address the need until a later time), or "referred" (i.e. the need requires referral to another program, service, or practitioner). In some cases there may be high need areas that cannot be declined or deferred without risk to the individual and must stay on the list as a treatment need. These should be the exceptions to the person-centeredness of this negotiation. These identified needs will be considered the basis for subsequent treatment goals and/or objectives and all recommendations and needs will be geared toward improving the functioning of the individual in life roles or reducing the distressing symptoms of his/her illness. **Examples: Debilitating depressive symptoms that result in isolation. Problems controlling anger. Repeated relapses with alcohol and drugs. Psychotic symptoms (i.e. delusions, hallucinations) that interfere with individual's ability to manage wellness and resume desired life roles. Social skills challenges that result in isolation. Challenges with ADL skills that interfere with individual's ability to integrate into the community. Lack of social supports to help individual in recovery. Self destructive thoughts/behaviors that threaten the individual's survival and ability to pursue desired roles.**
Individual Declined/ Deferred/ Referred Out Rationale(s)	Describe reasoning behind worker's decisions to defer or refer out work on any assessed needs. Also provide reasoning behind decisions by individual served to decline a recommendation at this time.
Level of Care / Indicated Service Recommendations	Recommend and record the least restrictive level of care that is safe for the individual based upon needs assessed and supported by the symptoms, behaviors, abilities and skill deficits documented earlier in the Comprehensive Assessment. Level of care should be directly linked to medical necessity which should be evidenced by the documentation throughout the assessment. Also, indicate the services that can be utilized within each level of care to meet the identified clinical needs and the service preferences provided by the individuals served/family.
Individual served/ guardian/ family response to recommendations	Indicate individual's/guardian's/family's response to treatment recommendations. If there is no contact with family/significant others, document in the progress note why there has been no contact and explain the benefits of involving their family.

Data Field	Signatures
Individual Served Signature	Signature of the individual served (optional).
Provider – Print Name/Credential, Signature, and Date	Legibly print name, credential(s) and signature of individual completing the Comprehensive Assessment. Record the date of signature.
Clinical Supervisor/Team Leader – Print Name/Credential, Signature, and Date (if needed)	Legibly print name, credential(s) and signature of the clinical Supervisor/Team Leader reviewing the Comprehensive Assessment and record the date of signature. (if needed)
Psychiatrist-Print Name/Credential, Signature, and date (if needed)	Legibly print name, credential(s) and signature of the Psychiatrist reviewing the Comprehensive Assessment and record the date of signature. (if needed)