Organization Name:	**Program Name:**	**Date:**
Individual's Name (First MI Last):	**Record #:**	**DOB:**

Reason for Update: ☐ Update of New Information ☐ Re-Admission ☐ Annual Update – Date of Admission:

Date of Most Recent Comprehensive Assessment: _____

Comprehensive Assessment Sections for Update

Check the box(es) next to the section(s) of the assessment (including addendums), which you are updating. Be sure to label all additional/updated information in your narrative with the number of the section of the Assessment or Addendum being updated.

☐ 1. Reason for Referral and Chief Complaint/Presenting Problem	☐ 11. Trauma History
☐ 2. Psychiatric Illness/Substance Use/Addictive Behavior History	☐ 12. Social/Leisure
☐ 3. Mental Health and Addiction Service Treatment History	☐ 13. Physical Health History
☐ 4. Social and Developmental Status	☐ 14. Mental Status, Suicide, Violence
☐ 5. Sexual History	☐ 15. Life Goals, Strengths, Abilities and Barriers
☐ 6. Vocation/Education/Employment	☐ 16. Diagnosis (Case Management Only)
☐ 7. Military Service	☐ 17. Prioritized Assessed Needs
☐ 8. Legal	☐ 18. Other:
☐ 9. Living Situation	☐ 19. Other:
☐ 10. Family History and Relationships	☐ 20. Other:

Update Narrative: List each assessment section being updated with narrative explanation below it.

SCREENING TOOLS

Was any evidence-based screening tool(s), for either mental health or substance use, utilized?: ☐ No ☐ Yes
If Yes, specify:

Diagnosis: ☐ No Change ☐ Change in Diagnoses Listed below ☐ DSM Codes ☐ ICD Codes

Check Primary	Axis	Code	Narrative Description
☐	Axis I		
☐			
☐			
☐			
☐	Axis II		
☐			
	Axis III		
	Axis IV	☐ No ☐ Yes	Problems with primary support group: If yes, describe:

Organization Name:	**Program Name:**	**Date:**
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		☐ No ☐ Yes	Problems related to the social environment: If yes, describe:
		☐ No ☐ Yes	Educational problems: If yes, describe:
		☐ No ☐ Yes	Occupational problems: If yes, describe:
		☐ No ☐ Yes	Housing problems: If yes, describe:
		☐ No ☐ Yes	Economic problems: If yes, describe:
		☐ No ☐ Yes	Problems with access to health care services: If yes, describe:
		☐ No ☐ Yes	Problems with interaction with the legal system/crime: If yes, describe:
		☐ No ☐ Yes	Other psychosocial and environmental problems: If yes, describe:
	Axis V	Current GAF:	Highest GAF in Past Year (if known):

Individual Served /Family/Guardian Expression of Service Preferences

1. Service Preferences:

Treatment Recommendations / Assessed Needs: ☐ No Additional Recommendations Clinically Indicated

A-Active, ID-Individual Declined, D-Deferred, R-Referred Out (If declined/deferred/referred out, please provide rationale)

	A	**ID***	**D***	**R***
1.	☐	☐	☐	☐
2.	☐	☐	☐	☐
3.	☐	☐	☐	☐
4.	☐	☐	☐	☐

***Individual Declined/Deferred/Referred Rationale(s) (**Explain why Individual Declined to work on Need Area; List rationale(s) for why Need Area(s) is Deferred or Referred Out below**).** ☐ None

1.

2.

3.

Further Evaluations Needed: ☐ None Indicated

☐ Psychiatric ☐ Psychological ☐ Neurological ☐ Medical ☐ Educational ☐ Vocational
☐ Visual ☐ Auditory ☐ Nutritional ☐ AOD Assessment ☐ Other:

Level of Care/ Indicated Services Recommendation: ☐ No change

Individual Served/Guardian/Family Response to Recommendations:

Organization Name:	**Program Name:**	**Date:**
Individual's Name (First MI Last):	**Record #:**	**DOB:**

Treatment Planning Updates

Change In IAP Required: ☐ No ☐ Yes (If Yes, complete the IAP Revision/Review Form to record needed changes in Goal(s),Objective(s), Interventions, Services, Frequency, and/or Provider type)

Individual Signature (Optional)**:**		**Date:**
Guardian Signature (Optional)**:**		**Date:**
Completed By - Print Name/Credentials:	**Staff Signature:**	**Date:**
Clinical Supervisor/ Professional Staff/ QHP/Team Leader - Print Name/Credentials (if needed):	**Clinical Supervisor/ Professional Staff/ QHP/Team Leader - Print Name/Credentials** (if needed):	**Date:**
Other - Print Name/Credentials (if needed):	**Other Signature** (if needed)**:**	**Date:**
Psychiatrist-Print Name/Credentials (if needed)**:**	**Psychiatrist Signature** (if needed)**:**	**Date**