| 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 | | | | | | | | |  | | 1. Trauma History | | | | | | | | | | |
|  | 1. Psychiatric Illness/Substance Use/Addictive Behavior History | | | | | | | | |  | | 1. Social/Leisure | | | | | | | | | | |
|  | 1. Mental Health and Addiction Service Treatment History | | | | | | | | |  | | 1. Physical Health History | | | | | | | | | | |
|  | 1. Social and Developmental Status | | | | | | | | |  | | 1. Mental Status, Suicide, Violence | | | | | | | | | | |
|  | 1. Sexual History | | | | | | | | |  | | 1. Life Goals, Strengths, Abilities and Barriers | | | | | | | | | | |
|  | 1. Vocation/Education/Employment | | | | | | | | |  | | 1. Diagnosis (Case Management Only) | | | | | | | | | | |
|  | 1. Military Service | | | | | | | | |  | | 1. Prioritized Assessed Needs | | | | | | | | | | |
|  | 1. Legal | | | | | | | | |  | | 1. Other: | | | | | | | | | | |
|  | 1. Living Situation | | | | | | | | |  | | 1. Other: | | | | | | | | | | |
|  | 1. Family History and Relationships | | | | | | | | |  | | 1. 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 CodesICD Codes | | | | | | | | | | | | | | | | | | | |
| **Check Primary** | | **Axis** | | | **Code** | **Narrative Description** | | | | | | | | | | | | | | | | |
|  | | Axis I | | |  |  | | | | | | | | | | | | | | | | |
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|  | | Axis II | | |  |  | | | | | | | | | | | | | | | | |
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|  | | Axis III | | |  |  | | | | | | | | | | | | | | | | |
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| Axis IV | | | No  Yes | | | Problems with primary support group:  If yes, describe: | | | | | | | | | | | | | | |
| 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 | | | | | | | | | | | | | | | | | | | | | | |
| 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  Visual | | | | Psychological  Auditory | | | Neurological  Nutritional | | Medical  Educational  AOD Assessment | | | | | | Vocational  Other: | | | | | | | |
| **Level of Care/ Indicated Services Recommendation:**      No change | | | | | | | | | | | | | | | | | | | | | | |
| **Individual Served/Guardian/Family Response to Recommendations**: | | | | | | | | | | | | | | | | | | | | | | |
| 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** | |