| 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 UpdateCheck 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 [ ]  YesIf 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:      |
| [ ]  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 IndicatedA-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**      |