



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.

<input type="checkbox"/> 1. Reason for Referral and Chief Complaint/Presenting Problem	<input type="checkbox"/> 11. Trauma History
<input type="checkbox"/> 2. Psychiatric Illness/Substance Use/Addictive Behavior History	<input type="checkbox"/> 12. Social/Leisure
<input type="checkbox"/> 3. Mental Health and Addiction Service Treatment History	<input type="checkbox"/> 13. Physical Health History
<input type="checkbox"/> 4. Social and Developmental Status	<input type="checkbox"/> 14. Mental Status, Suicide, Violence
<input type="checkbox"/> 5. Sexual History	<input type="checkbox"/> 15. Life Goals, Strengths, Abilities and Barriers
<input type="checkbox"/> 6. Vocation/Education/Employment	<input type="checkbox"/> 16. Diagnosis (Case Management Only)
<input type="checkbox"/> 7. Military Service	<input type="checkbox"/> 17. Prioritized Assessed Needs
<input type="checkbox"/> 8. Legal	<input type="checkbox"/> 18. Other:
<input type="checkbox"/> 9. Living Situation	<input type="checkbox"/> 19. Other:
<input type="checkbox"/> 10. Family History and Relationships	<input type="checkbox"/> 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
<input type="checkbox"/>	Axis I		
<input type="checkbox"/>			
<input type="checkbox"/>			
<input type="checkbox"/>			
<input type="checkbox"/>	Axis II		
<input type="checkbox"/>			
<input type="checkbox"/>	Axis III		
<input type="checkbox"/>			
<input type="checkbox"/>	Axis IV	<input type="checkbox"/> No <input type="checkbox"/> Yes	Problems with primary support group: If yes, describe:

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	<input type="checkbox"/> No <input type="checkbox"/> Yes	Problems related to the social environment: If yes, describe:					
	<input type="checkbox"/> No <input type="checkbox"/> Yes	Educational problems: If yes, describe:					
	<input type="checkbox"/> No <input type="checkbox"/> Yes	Occupational problems: If yes, describe:					
	<input type="checkbox"/> No <input type="checkbox"/> Yes	Housing problems: If yes, describe:					
	<input type="checkbox"/> No <input type="checkbox"/> Yes	Economic problems: If yes, describe:					
	<input type="checkbox"/> No <input type="checkbox"/> Yes	Problems with access to health care services: If yes, describe:					
	<input type="checkbox"/> No <input type="checkbox"/> Yes	Problems with interaction with the legal system/crime: If yes, describe:					
	<input type="checkbox"/> No <input type="checkbox"/> 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: <input type="checkbox"/> 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.				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*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). <input type="checkbox"/> None							
1.							
2.							
3.							
Further Evaluations Needed: <input type="checkbox"/> None Indicated <input type="checkbox"/> Psychiatric <input type="checkbox"/> Psychological <input type="checkbox"/> Neurological <input type="checkbox"/> Medical <input type="checkbox"/> Educational <input type="checkbox"/> Vocational <input type="checkbox"/> Visual <input type="checkbox"/> Auditory <input type="checkbox"/> Nutritional <input type="checkbox"/> AOD Assessment <input type="checkbox"/> Other:							
Level of Care/ Indicated Services Recommendation: <input type="checkbox"/> No change							
Individual Served/Guardian/Family Response to Recommendations:							



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Treatment Planning Updates			
Change In IAP Required: <input type="checkbox"/> No <input type="checkbox"/> 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: