Child/Adolescent Comprehensive Assessment

The Child/Adolescent Comprehensive Assessment (C/A CA) provides a standard format to assess the mental health, substance use and functional needs of children. This assessment provides a summary of assessed needs that serve as the basis of goals and objectives on the Individualized Action Plan. The C/A CA may be completed in concert with the Child and Adolescent Needs and Strengths (CANS) assessment.

Follow agency policies and procedures when choosing to complete Child or Adult Comprehensive Assessment for transitional age youth (16-21)

Complete the "Transition to Adulthood section for children 14.5 years and older. –
If completing the CANs assessment, complete significant history sections only.

Data Field	Identifying Information Instruction
Person's Name	Record the first name, last name, and middle initial of the child. Order of name is at agency discretion.
Record Number	Record your agency's established identification number for the child.
Date of Admission	Record the date of admission per agency policy (this should be the first service date for this service episode).
Organization Name	Record the organization for whom you are delivering the service.
DOB	Record the child's date of birth
Gender	Indicate child's gender by checking the appropriate box. If check "Transgender" box, also complete box of current gender designation for insurance purposes.
Data Field	**Presenting Concerns**
Referral Source and Reason for Referral	Document the referral source and reason the child was referred for services, from the child's/family's and the referent's point of view.
What Occurred to Cause the Person to Seek Services Now (Note Symptoms, Behavioral and Functioning Needs)	Record (in person's own words) precipitating factors as reported by the child/family or others that has led up to the event that caused the person to seek services. Record troublesome symptoms, behaviors and/or problems affecting day-to-day functioning, relationships and work/school, as reported by the child/family. Examples: If the occurrence was having trouble in school: "Feeling like I have no energy at school, getting into trouble in class, and coming in late or skipping school altogether 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, have cut self in past, and I was drinking when I cut myself this time."
Data Field	**Custody**
Custody	Check all boxes that reflect the current custody arrangement for the child. If applicable, include the DSS Caseworker's name. Complete Legal status Addendum if person needs a guardian.
Is there a need for a Legal Guardian, Rep Payee, or Conservatorship?	Check the appropriate box and provide comments regarding the need for a Legal Guardian, Representative Payee, or Conservatorship if needed. If *yes*, complete the Legal Status Addendum.
Data Field	**Living Situation**
What is the person's current living situation	Check the box (or boxes) to indicate what the person's current living situation is. You are not required to check off one box under each category (i.e., person's home, residential care/treatment facility, other).
Person's Home	Check if person served currently rents or owns his/her home. If person does not currently reside in independent housing, leave blank and complete the next section.
Residential Care/Treatment Facility	Check if person served is in one of these living situations. If person owns or rents an independent living situation but currently resides in residential care or a treatment facility, complete this and the previous section.

Other	Check appropriate current living situation if not already noted above.
Contact name and phone number	If a situation in o*ther* is checked, note here the contact name and phone number of the person/facility with whom the person served is living.
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 yes, provide comments that illustrate the situation.
Comments	Add comments about the person's current living situation as necessary.
Data Field	**Family**
Family	Attach Genogram/ Ecomap if completed. Record each household member's name, his/her relationship to the person served and his/her age. **Examples: Mother, father, sister, family friend, foster brother/sister, step-parent.** Record the household's street address if different from the address listed on the Personal Information form. Record all other significant family members and others not residing in household currently. Record significant history regarding family functioning. Record current status of family functioning (if CANS assessment not completed).
Data Field	**Social Functioning**
Significant History Regarding Social Functioning	Record significant history regarding social skills and relationships. Include parental and other family obligations of the child as well as the medical and psychiatric history of the family.
Current Status of Social Functioning	Describe current status of social skills and relationships.
Data Field	**Medical/Physical**
Allergies	List all known food, medication and environmental allergies for the person. Note drug sensitivities. If no allergies/drug sensitivities are known, check *No known allergies* and skip to next question.
Significant History Regarding Medical/Physical Health	Complete significant history regarding physical health, as reported by the child/family members or refer to attached Physical Health Assessment. Record current status of medical/physical functioning (if CANS assessment not completed). This must include speech and language, hearing, visual, intellectual, sensory and other. Include allergies.
Current Status of Medical/Physical Functioning	Record current health status or physical limitations including smoking, nutrition, pain and emergency health needs.
Primary Care Provider and Dentist Name and Credentials/Address/Telephone Number/Fax/Date of Last Exam	Complete table with name of PCP and Dentist for the person as well as their address, phone number, fax number and date of last physical and dental exams.
Data Field	**Developmental**
Significant History Regarding Developmental Functioning	Record significant history regarding developmental functioning. Include information regarding prenatal history, developmental milestones, any disruptions in achievement of developmental tasks, or other pertinent information regarding development. **Examples: Child did not walk until age 2 ½; child was unable to successfully separate from mother to attend preschool.** Record current status of developmental functioning (if CANS assessment not completed.
Current Status of	Record current status of developmental milestones achieved or delays in attainment.

Developmental Functioning	
Data Field	**Self-Care**
Significant History Regarding Self-Care	Record significant history regarding self-care skills (for example toileting, grooming, eating, etc.).
Current Status of Self-Care	Record current status of self-care functioning (if CANS assessment not completed). Include assistive technology and special communication needs. Include ability to self-preserve.
Data Field	**Community**
Significant History Regarding Community	Record significant history regarding use of community supports, connections to specific people in his/her neighborhood, and a stake/sense of belonging in the neighborhood.
Current Status of Community	Record current status of community functioning (if CANS assessment not completed).
Data Field	**Education**
Significant History Regarding Learning Impairments	Record significant history regarding learning impairments. Include information on preferred learning style.
Current Status of Learning Impairments	Record current status of learning impairments (if CANS assessment not completed).
Significant History Regarding School Behavior	Record significant history regarding school behavior.
Current Status of School Behavior	Record current status of school behavior (if CANS assessment not completed).
Significant History Regarding School Achievement	Record significant history regarding academic achievement.
Current Status of School Achievement	Record current level of student's academic achievement (if CANS assessment not completed).
Significant History Regarding School Attendance	Record significant history regarding school attendance and absences.
Current Status of School Attendance	Record current status of school attendance or absence.
Data Field	**Child Behavioral/Emotional Needs**
Significant History Regarding Behavioral/Emotional Needs	Record significant history regarding behavioral/emotional needs.
Current Status of Child's Behavioral/Emotional Needs	Record current status of behavioral/emotional needs (if CANS assessment not completed). Include effect of family on child's mental illness/addiction and affect of child's mental illness/addiction on family.
Needs	Check all applicable boxes for specific behavioral/emotional needs of child.
Describe All Needs Checked	Record description of all needs checked

Data Field	Child Risk Behaviors
Significant history regarding risk behaviors	Record significant history regarding child risk behaviors.
Current status of child risk behaviors.	Record current status of child risk behaviors (if CANS assessment not completed).Check all applicable boxes for specific child risk behaviors and record description of all behaviors checked.
Risk Behaviors	Check all applicable boxes for risk behaviors exhibited by child.
Describe All Behaviors Checked	Record description of all needs checked
Data Field	**Child Strengths**
Significant Family strengths	Record significant history regarding family strengths.
Current status of family strengths	Record current status of family strengths (if CANS assessment not completed). Include the presence of a sense of family identity, love, respect and communication and commitment between family members
Significant history regarding Interpersonal Relationships	Record significant history regarding interpersonal history achievements and strengths.
Current status of Interpersonal functioning	Record current status of interpersonal history achievements and strengths – note child's social and relationship skills and ability to maintain relationships over time (if CANS assessment not completed).
Significant history regarding Attitude of Optimism	Record significant history regarding attitude of optimism and orientation toward the future.
Current status of Attitude of Optimism	Record current status of attitude of optimism and orientation toward the future (if CANS assessment not completed).
Significant history regarding Educational Strengths	Record significant history regarding child's educational strengths as well as areas of interest **Example: Susan usually achieves A's and B's**
Current status of Educational Strengths	Record current status of child's educational strengths as well as areas of interest (if CANS assessment not completed). Note if the child enjoys/excels/looks forward to school.
Significant history regarding Vocational Strengths	Record significant history regarding child's vocational strengths and vocational skills developed including employment history.
Current status of Vocational Strengths	Record current status of child's vocational strengths (if CANS assessment not completed).
Significant history regarding Talents and Interests	Record significant history regarding child's talents and interests, including hobbies, artistic interest, and skills developed.
Current status of Talents	Record current status of child's talents and interests (if CANS assessment not completed).

and Interests	
Significant history regarding Spiritual / Religious Strengths	Record significant history regarding spiritual / religious strengths, note the child's and family's experience of support and comfort from religious/spiritual involvement.
Current status of Spiritual / Religious Strengths	Record current status of child's spiritual / religious strengths (if CANS assessment not completed).
Significant history regarding Community Life Strengths	Record significant history regarding community life strengths. Note connections with community institutions and influential community members such as coaches, teachers, after school activities, religious or civic activities.
Current status of Community Life Strengths	Record current status of child's community life (if CANS assessment not completed). Does this include play? Can this be cued.
Significant history regarding Resiliency	Record significant history regarding demonstration of resiliency. Include the child's ability to acknowledge his/her strengths and abilities and his/her use of strengths to address their needs.
Current status of Resiliency	Record current status of child's resiliency (if CANS assessment not completed).
Data Field	**Child Acculturation**
Significant history regarding Language	Record significant history regarding the child's first and other spoken/written language skills. Note who in family speaks what language(s) and whether the child interprets for their parents/family.
Current status of Language	Record current status of child's language (s) (if CANS assessment not completed).
Significant history regarding Cultural Identity	Record significant history regarding child's cultural identity. Note if the child has access or difficulty joining with others who share a common culture
Current status of Cultural Identity	Record current status of child's cultural identity (if CANS assessment not completed).
Significant history regarding Cultural Ritual	Record significant history regarding child's cultural ritual(s). Note if the child has opportunities to engage in rituals relevant to his/her culture.
Current status of Cultural Ritual	Record current status of child's cultural ritual(s) (if CANS assessment not completed).
Significant history regarding Cultural Stress	Record significant history regarding child's cultural stress. Note if child experiences problems/hostility from others due to his/her cultural identity.
Current status of Cultural Stress	Record current status of child's cultural stress (if CANS assessment not completed).
Data Field	**Transition to Adulthood Complete for child 14.5 years or older**
Significant history regarding Independent Living	If the child/adolescent is approaching adulthood record significant history regarding child's independent living skills.
Current status of Independent Living	If the child/adolescent is approaching adulthood, record current status of child's independent living skills (if CANS assessment not completed).

Significant history regarding Transportation	Record significant history regarding child's transportation skills.
Current status of Transportation	Record current status of child's transportation skills (if CANS assessment not completed).
Significant history regarding Parenting Roles	If applicable, record significant history regarding child's parenting roles.
Current status of Parenting Roles	If applicable, record current status of child's parenting skills (if CANS assessment not completed).
Significant history regarding Personality Disorder	If applicable, record significant history regarding development of personality disorder.
Current status of Personality Disorder	If applicable, record current status of child's personality disorder (if CANS assessment not completed).
Significant history regarding Intimate Relations	If applicable, record significant history regarding child's intimate relations. This should include sexual history and concerns
Current status of Intimate Relations	If applicable, record current status of child's intimate relations (if CANS assessment not completed).
Significant history regarding Medication Adherence	If applicable, record significant history regarding child's medication adherence. Record current status of child's medication adherence (if CANS assessment not completed).
Current status of Medication Adherence	If applicable, record current status of child's medication adherence (if CANS assessment not completed).
Significant history regarding Educational Attainment	Record significant history regarding child's educational attainment.
Current status of Educational Attainment	Record current status of child's educational attainment (if CANS assessment not completed).
Significant history regarding Victimization	If applicable, record any significant history of child's victimization.
Current status of Victimization	If applicable, record current status of child's victimization (if CANS assessment not completed).

Data Field	Substance Use/Addictive Behavior History
Does person report a history of, or current, substance use/addictive behavior concerns?	At a minimum, a basic screening instrument following agency protocols (e.g. CAGE, GAIN,,ESM/BSAS) should be completed in addition to person's self report and information available from other sources. If there are no significant indications of substance abuse or addiction problems past or present based on the screening and clinical judgment, check *No* and skip to the next section. If *yes* complete and attach the Substance Use/Addictive Behavior History Addendum
Data Field	**Mental Health Service History**
None Reported	If None Reported, skip to the Medication Information section

Document Services used	Check all boxes that apply.
Type of Service	Record the type of service received; be as specific as possible. **Examples: Inpatient, PHP, Outpatient Group.**
Dates of Service	Record the approximate date range of service.
Reason	Record the reason that person received treatment. **Example: Depression**
Name of Provider / Agency	Record the name of the provider and/or agency.
Completed?	Check if person completed the originally planned service. **Example: Check *No* if person discharged himself against doctor's orders.**
Comments on Effectiveness of Mental Health Services Received	Record efficacy of specific services and treatment received.
Current Diagnoses	Record all past/current psychiatric diagnoses known by the person, significant others, former clinician(s) or identified in former records. This is not an attempt to formulate a diagnosis, only information gathering. Identify the source(s) of the information. **Examples: The person, hospital records, primary support person, case manager etc.**
Data Field	**Medication Information** (Include All Non-Psych Meds/Prescription/OTC, Herbal)
Medication	Record past and 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 person 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 person remembers. This is especially important for current medications that the person is taking.
None Reported	If None Reported, skip to the next question.
Dosage / Route / Frequency	Record the dosage for each medication taken by the person. It is suggested that dosage be recorded as unit/time of day. **Example: 50 mg PO @ 9AM, 10 cc @ 5 PM and 20cc @ 8PM.**
Reported Side-effects	Describe any reported side-effects. Document the degree of distress the person experienced or experiences due to each side-effect.
Adherence *(WA = With Assistance)*	Check the box that best indicates if the person takes the medication as prescribed or suggested, or if the person needs assistance to adhere to the medication regimen.
Prescriber	Record the name of the physician or other licensed prescriber who prescribed the listed medication.
Comments on 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 person doesn't take meds as prescribed, side-effects and any specific medications the person would like to avoid taking in the future.
Data Field	**Legal Status and Legal Involvement and History**
Does the person have a history of, or current involvement with the legal system (i.e., legal charges)?	Check the appropriate box. If *yes*, complete the Legal Involvement and History Addendum
Data Field	**Trauma History Addendum** (Describe in Comments Section Each Element Checked)
Multiple Fields: **Physical Abuse; Domestic Violence/ Abuse; Elder Abuse; Financial Abuse; Community Violence*; Physical Neglect; Verbal/Emotional Abuse; Sexual Abuse/Molestation; Military Trauma; Other**	For each traumatic event, describe specifics of trauma in the comments section to the right. Note if experience was single event or sustained over time. *Example: Gang violence

Trauma; Witness to Violence; Other	
Current Involvement by	Check the box(es) that apply. Add comments if necessary.
Additional Mandated Report Required?	If the person reports any activity that requires interviewer to report to an oversight agency, check the box(es) that apply. Add comments if necessary.

Data Field	Mental Status Exam
Mental Status Examination	Avoid judgmental perceptions. Take into account cultural differences. Think of creating a picture of the person served so that anyone reading the results of the exam would be able to clearly perceive the person just as you do. Assessment items are "in the moment", in other words as the person presents to you at the present time. There are other sections of the assessment form that address historical information.
Appearance	Check appropriate boxes to describe physical appearance, taking into account culture and age of person.
Eye Contact	Check boxes that apply.
Build	Check boxes that apply.
Posture	Check boxes that apply.
Body Movement	Check boxes that apply.
Behavior	Check boxes that apply.
Speech	Check boxes that apply.
Emotional State-Mood	Sustained internal emotional state of a person. This describes the typical, more consistent emotional state of the person. **Examples: Typical Mood is balanced and WNL; Mood is typically subdued; Mood is typically anxious and irritable. Check boxes that apply.**
Emotional State-Affect	External expression of present emotional content. This describes the emotional state presently observed or described. **Examples: Person describes inability to sleep through the night (sleep disturbance), loss of appetite (appetite disturbance), irritability over the past three weeks; Person appears somewhat elated (inappropriate), describes lack of fatigue although has not slept for three nights (sleep disturbance). Check boxes that apply.**
___**Constricted**	Feelings demonstrated are subdued and do not appear to present the full range usually seen in people of this culture (cultural expectations are vital considerations in this area).
___**Flat**	No feeling states are demonstrated.
___**Inappropriate**	Demonstrated feelings do not match with subject discussed (e.g. laughing while discussing a trauma experience).
___**Changeable**	Demonstrated feelings shift rapidly from one state to another. Called changeable on the form.
___**Full Range**	Demonstrates a full range of feelings.
___**Panic attacks or symptoms**	Person describes recent anxiety/panic symptoms including: shortness of breath, rapid breathing/hyperventilating, extreme discomfort with crowds or open places, sweatiness or dizziness.
___ **Sleep disturbance**	Person describes recent difficulties sleeping including generally reduced or increased sleep, difficulties falling asleep (longer than 1 hour), and difficulties remaining asleep, early morning awakening or no perceived need for sleep for longer than a day.
___ **Appetite disturbance**	Person describes marked changes in appetite including but not limited to incessant hunger or lack of hunger for more than 1-2 days.
Facial Expression	Check boxes that apply.
Perception	
___ WNL	If there are no perceptual disturbances, check here
___Illusions	A misperception or misinterpretation of a real external stimulus, such as hearing the rustling of leaves as the sound of voices.
___Depersonalization	An alteration in the perception or experience of the self. The person will describe feeling as though he/she is "not really there" , detached from or feeling as though he/she is an outside observer to his/herself or as if in a dream.
___De-realization	An alteration in the perception or experience of the external world so that it seems strange or unreal (e.g., people may seem unfamiliar or mechanical).
___Re-experiencing	Re-experiencing is the recurrence or reliving of a past experience.
Hallucinations	Hallucinations are perceptions with a compelling sense of reality but occurs in the

	absence of stimuli. Hallucinations should be distinguished from illusions, in which an actual external stimulus is misperceived or misinterpreted. The person may or may not have insight into the fact that he or she is having a hallucination.
___Auditory	Usually described as voices. To assess, ask the individual, “Do you ever hear anyone talking but cannot tell where the voice is coming from?” If they answer yes, ask if he/she can tell what the voice is saying and he/she can identify the voice.
___Visual	Visual hallucinations are usually only experienced by individuals who have ingested an illicit drug or drug overdose, or someone who has experienced a head injury. It is important to ask the person served to describe the visual hallucination and under what circumstances it occurs.
___Olfactory	A hallucination involving the perception of odor, such as of burning rubber or decaying fish. This is usually a symptom of a neurological disorder or brain injury.
___Gustatory	A hallucination involving the perception of taste (usually unpleasant). This is usually a symptom of a neurological disorder or brain injury.
___Tactile	A hallucination involving the perception of being touched or of something being under one's skin. This is more typical in substance dependent individuals (especially alcoholics) who are detoxifying. The most common tactile hallucination is the feeling that bugs are crawling under the skin.
___Command**	Command hallucinations are voices telling someone to do something dangerous or harmful (e.g. “kill him”).
Thought Content	
Delusions	Beliefs in things that are not true (e.g. “Aliens have planted a sensor in my head”).
___None reported	No observable evidence of delusions or delusions are denied.
___Grandiose	Thoughts of exaggerated and somewhat improbable status or success: “Mattel is going to buy my game and I’ll make millions.”
___Persecutory	“People are trying to kill me.”
___Somatic	Physical complaints in the absence of any real cause. Fear that stomach pains are cancer even after a doctor has examined him/her and found no health problem.
___Illogical	“My neighbors are throwing away babies in the trash. I can hear them at night.”
___Chaotic	“The world is going to end on New Year’s Day.”
___Religious	“I am the second coming.”
Other Content	
___Preoccupied	Person appears to be lost in thought, engrossed or absorbed to such a degree that communication with others is compromised.
___Obsessional	Persistent and disturbing intrusive thoughts, ideas or feelings.
___Guarded	Statements, ideas, responses are brief and person appears reluctant to provide details or information.
___Phobic	Exaggerated fear inexplicable to the person (e.g. airplane flight, spiders, heights).
___Suspicious	Inclined to suspect, especially inclined to suspect evil; distrustful
___Guilty	Focused on unrealistic self-blame.
___Thought broadcasting	“I can make those people think what I am thinking.”
___Thought insertion	“Those people are sending their ideas to me.”
___Ideas of reference	“Those people standing together over there are talking about me.”
Self Abuse Thoughts	Take care to differentiate between thoughts of self abuse/self harm behaviors and suicidal actions.
___None reported	No acknowledgment or evidence of thoughts of self harm behaviors.
___Cutting**	Thoughts of any type of scratching or cutting that draws blood or damages the skin or a body part
___Burning**	Thoughts of putting hot objects, including open flames in contact with any part of the body so as to damage the skin or a body part.
___Other self mutilation**	Thoughts of pulling out hair, damaging eyes , etc.
Suicidal Thoughts	
___None reported	Person denies thoughts of taking his or her life.
___Passive Suicidal Ideation**	Person admits to passively thinking about taking his or her life but does not intend to

	take action on those thoughts.
___Intent**	Person admits to seriously considering taking his or her life. This goes beyond feelings of hopelessness or frustration.
___Plan**	Person describes a viable, actual plan to take his or her life.
___Means**	Person has in his/her possession the object or objects necessary to complete his/her plan (e.g. stock-pile of pills, gun).
Aggressive Thoughts	
___None reported	Person denies thoughts of harming another person.
___Intent**	Person admits to seriously considering harming another person. This goes beyond feelings of anger or frustration.
___Plan**	Person describes a viable, actual plan to harm another person.
___Means**	Person has in his/her possession the object or objects necessary to complete his/her plan (e.g. knife, gun).
Thought Process	
___WNL	Within Normal Limits) - Thoughts are clear, logical and easily understood.
___Incoherent	Thoughts, words or phrases are joined together without a logical or meaningful connection or relevance, and are not understandable despite repeated attempts to explain.
___Circumstantial	Pattern of speech in which the person is not able to respond directly to a question but will provide a lot of related information.
___Decreased thought flow	Responses and statements are slow and have a paucity of details.
___Blocked	The person has consistent difficulty responding to questions. Answers or statements are either very brief and appear difficult to produce or there are no responses at all.
___Flight of ideas	A nearly continuous flow of accelerated speech with abrupt changes from topic to topic that are usually based on understandable associations, distracting stimuli, or plays on words. When severe, speech may be disorganized and incoherent.
___Loose	A disturbance of thinking shown by speech in which ideas shift from one subject to another that is unrelated or minimally related to the first. The speaker gives no indication of being aware of the disconnectedness, contradictions, or illogicality of speech. To assess for loose thinking, ask the person to explain a proverb. For example, “People who live in glass houses shouldn’t throw stones”. An example of loose thinking would be: “If you don’t punch holes in the top, everyone dies.”
___Racing	Demonstrates rapid thinking that is not necessarily bizarre or unusual but thought production is faster than most people typically demonstrate.
___Increased thought flow	Responses and statements are rapid and rich with detail.
___Concrete	To assess for concrete thinking, ask the person to explain a proverb. For example, “People who live in glass houses shouldn’t throw stones”. An example of concrete thinking would be: “Rocks break glass.”
___Tangential	A question or statement will prompt a response that begins with one subject and ends with an entirely different subject only vaguely related to the first subject, if at all.
Intellectual Functioning	
___WNL	No apparent deficits in intellectual functioning.
___Lessened fund of common knowledge	Ask: “Who is the President of the United States?” “Who was President before him or her?”
___Short attention span	Person demonstrates difficulty staying on topic or attending to a task.
___ Impaired concentration	Person is distracted from basic tasks
___Impaired calculation ability	Ask the person to count backwards from 100 by 7’s.
Intelligence Estimate	This can be an estimate only in the absence of any accepted intelligence tests or information from other sources. Keep in mind that some psychiatric disorders (depression) can negatively impact IQ scores. Intelligence is generally accepted to be a person’s capacity to absorb information and solve problems.
___MR	IQ under 70 on the Wechsler scale.
___Borderline	IQ from 70-79 on the Wechsler scale.

___Average	IQ from 90-109 on the Wechsler scale. (80-89 is considered “low average”).
___Above average	IQ above 110 on the Wechsler scale.
___No formal testing	Note if there is no record of formal testing of intellectual functioning (e.g. MMPI)
Orientation	
___WNL	Check here if the person can correctly respond to the following questions about person, time and place.
Disoriented to:	
___Person	Does the person know his/her correct name, age and some facts about his/her life.
___Time	Does the person know what time and day it is (within a few hours and days).
___Place	Does the person know where he or she is?
Memory	
___WNL	Check here if the following three areas are responded to sufficiently.
Impaired:	
___Immediate recall	At the beginning of the assessment interview, tell the person you are going to state three objects that you will ask him or her to recall later in the interview. Use three basic objects such as tree, car and floor. After 10-15 minutes, ask the person to tell you what the three items were that you asked him/her to remember from the beginning of the interview.
___Recent memory	Can the person tell you what they had for breakfast or what he/she did first thing this morning?
___Remote memory	Can the person describe events form his/her childhood or in the past?
Insight	Check the most appropriate description of the person’s current functioning.
Judgment	
___WNL	Decision making abilities appear intact and sufficient for day-to-day functioning.
Impaired ability to make reasonable decisions	Utilize scenarios to assess: If you were in a crowded movie theatre and noticed there was a fire off to the side in a hallway, what would you do? If you found a fully addressed and stamped envelope on the sidewalk, what would you do?
___Some	
___Severe**	
Past attempts to Harm to Self or Others	Check the all boxes that apply and comment on all past attempts.
Comments	Add any necessary comments about findings from the MSE.
**	**Checking any item with ** requires an immediate risk and/or lethality assessment.**
Data Field	**Summary of Assessed Needs Including Functional Domains**
Check all Current Need Areas	Check all current need areas for the person. Each *Assessed Needs Area* addressed will tie directly to the Individualized Action Plan and constitutes the beginning of the order for treatment. *Need Areas* should be determined based on assessment areas above with emphasis on those areas that interfere with or prevent assumption or continuation of the person’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.
Person Served Desires Change Now?	Check the box that applies.
Data Field	**Service Preferences**
Service Preferences	It is important that the clinician engage in a meaningful recovery focused dialogue with the person (and/or family/other supports) which allows the person (and/or

	family/other supports) 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 person (and others involved with the person) based on the prioritized areas covered in the Assessed Needs above. Include the person's preferences to develop or have available additional natural and community supports, as a part of his/her Recovery Process. If applicable to the person, discuss peer support, family education, other support, housing, transportation, social opportunities, and community involvement. Identify available resources. Discuss the person'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. *Note: For billing Medicaid or Medicare, at least one clinical care service must be selected.
Data Field	**Clinical Formulation – Interpretative Summary**
This Clinical Summary is Based Upon Information Provided By	Check the box(es) that apply.
Interpretive Summary	Do not duplicate the information provided earlier in this document. Instead, provide a brief analysis that blends the findings and opinions of the interviewer(s) and the preferences of the person/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 person's cultural and developmental context. Summarize the person's motivation for treatment and support, readiness for change, potential barriers to change and preferred learning style(s). Record the family's willingness and ability to be involved in treatment. Finally, assess person's strengths and assets in the areas of personal 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 person's goals Follow agency policies and procedures to determine the appropriate provider to complete the Interpretive Summary.
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 person. 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. Up to two Axis I and Axis II diagnoses can be recorded. 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, II, III, IV, V	
Code	Indicate the ICD or DSM numerical or alphanumerical code.
Narrative Description	List the narrative description of the code in either DSM or ICD terminology.

Data Field	**Further Evaluations Needed**
Further Evaluations Needed	Check the box(es) that identify additional assessments needed for the child (if any).

Was Outcomes tool administered?	Check yes or no. If Yes, note name of tool utilized (e.g. CANS, GAIN, SF-36, TOP)
Data Field	**Prioritized Treatment Recommendations per Summary of Assessed Needs**
Prioritized Assessed Needs	The information for this section comes from the Assessed Needs Checklist. Identify and record *Assessed Needs* of the child. In some cases there may be high need areas that cannot be deferred without risk to the child 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 child in life roles or reducing the symptoms of his/her illness. **Examples: Decrease symptoms of depression; learn anger management strategies; improve personal hygiene; develop Wellness and Recovery Action Plan (WRAP) to decrease likelihood of psychiatric relapse; learn pain management skills; improve medication management skills; reduce suicidal ideation; improve social skills; reduce dissociation; learn stress management skills; improve sleep hygiene skills; increase personal safety skills.** Assess all Recommendations/Needs as ACTIVE, PERSON or FAMILY/GUARDIAN DECLINED, DEFERRED, or REFERRED OUT. Include rationale for all Declined, Deferred and Referred Recommendations/Needs.
Person or Family/Guardian Declined/Deferred/Referred Out Rationale(s) (Explain why Person or Family/Guardian Declined to work on Need Area; List rationale(s) for why Need Area(s) is/are Deferred/Referred Out below)	Describe reasoning behind worker's decisions to defer or refer out work on any assessed needs. Also provide reasoning behind decisions by person served or family/guardian to decline a recommendation at this time.
Level of Care / Indicated Service Recommendation	Recommend and record the least restrictive level of care that is safe for the person based upon needs assessed and supported by the symptoms, behaviors, abilities and skill deficits documented in 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 persons served/family. **Examples: Outpatient level of care with emphasis on Community Support; individual therapy and medication management services.** *****Note: For organizations without formal levels of care, list the services that are being recommended.
Will person's family be involved with treatment?	Choose Yes or No response. If Yes, please describe in what ways/to what extent family will be involved. Include family's response to recommendations, the involvement of family in the assessment process, state agency involvement and other supports.

Data Field	Staff Signatures
Provider – Print Name/Credential	**Legibly** print name and credentials of the provider completing the Comprehensive Assessment.

Date	Next to each signature record the date of the signature.
Supervisor – Print Name/Credential (if needed)	If the diagnosis is rendered by a clinician other than the clinician printing his/her name above, then the clinician rendering the diagnosis must print his/her educational level and highest license level.
Date	Next to each signature record the date of the signature.
Provider Signature	**Legible** signature of person completing the Assessment.
Date	Next to each signature record the date of the signature.
Supervisor Signature (if needed)	If the diagnosis is rendered by a clinician other than the clinician signing his/her name above, then the clinician rendering the diagnosis must provide his/her signature and record his/her educational level and highest license level.
Child/Guardian Signature (Optional, if appropriate)	**Legibly** record the signature of the child/guardian to be served by the agency indicating his/her] understanding and acceptance of the treatment recommendation/assessed needs.
Date	Next to each signature record the date of the signature.
Next Appointment / Date / Time	Record the next appointment for the child including date and time.