Comprehensive Assessment Update – Child/Adolescent Version

This form has been designed to reduce provider agency risks and to save time. It provides a standard and efficient format for updating diagnostic information, re-admitting persons served (according to agency policy and procedures), and/or updating the clinical formulation and treatment recommendations. This new/additional information, which is often not easily identifiable in progress notes, creates audit risks for provider agencies. It must be clear to auditors how assessed needs, treatment recommendations and treatment are linked, especially when the information in the diagnostic assessment is outdated.

This form does not replace initial evaluations or assessments.

It is recommended that this form be kept in date order in the comprehensive assessment portion of the child's record. In all cases, provider agencies should determine whether the new/additional information contained in this form requires an updated Individual Action Plan (IAP) to be completed.

This form can be used whenever the provider believes that updated diagnostic information should be included in the medical record. Some organizations may want to routinely require updates on an annual basis, or when the person returns to care within a fairly short time period, or when the person changes level of care. The completion of a Comprehensive Assessment Update form does not necessarily assume billing of a comprehensive assessment service. For example, data obtained during an individual therapy session that constitutes important new assessment information can be recorded on the Comprehensive Assessment Update while the service itself would have been documented and billed as Individual Therapy.

Data Field	Identifying Information
Person's Name	Record the first name, last name, and middle initial of the person being served. Order of name is at agency discretion.
Record Number	Record your agency's established identification number for the person.
Date of Admission	Record the date of admission per agency policy (this should be the first service date for this service episode).
Organization/Program Name	Record the organization and program for which you are delivering the service.
DOB	Record the person's date of birth
Gender	Indicate person's gender by checking the appropriate box. If checking "Transgender" box, also complete box of current gender designation for insurance purposes.
Data Field	**Section I: Reason for Update**
Annual Update, Re-Admission and Interim Update of New Information	Check the appropriate box to indicate whether the Update is: • an Annual Update of the Comprehensive Assessment (if required by agency policy and procedures and/or accreditation), • a Re-Admission Update for a child who left services and has returned to services within one year of the date of the last Comprehensive Assessment in the health record, or • an Interim Update of New Information while the child is in service that provides a therapeutic basis for additional services. Refer to the introduction above for clarification of each type of indicator.
Data Field	**Date of Most Recent Assessment**
Date of Most Recent Comprehensive Assessment	Enter the date of the last Comprehensive Assessment in the health record for the child.

Data Field	Child/Adolescent Comprehensive Assessment Section(s) for Update
Comprehensive Assessment Sections	Check all applicable boxes next to the section(s) of the Comprehensive Assessment being updated. All additional information being updated must be labeled in the narrative section of this form with the Comprehensive Assessment section heading. * Updates may require an IAP Revision or a new IAP. Annual Updates and Re-Admissions may require a new IAP if there are changes to treatment including goals, objectives and services offered.
Data Field	**Update Narrative**
Update Narrative	Provide a narrative explanation for each box selected in the section above. List each as a separate heading and write the narrative below.
Signature/Credentials	If the above sections are completed by an unlicensed staff (e.g., CSP Outreach Worker), the staff completing these sections signs here and adds his or her credentials. *The remainder of this document must be completed by a licensed clinician who will sign in the box below and again at the bottom of the completed document.
Date	Enter date the unlicensed staff completed and signed Section I.
Data Field	**Section II: Diagnosis Change**
Diagnosis Change	If there is any change or addition to the diagnosis, this section is used to record a full diagnostic picture including any changes to diagnoses. **Check the correct box designating no change in diagnosis or all current diagnoses.** 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-10 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:** Check if using ICD-9 or ICD-10 codes. List codes in appropriate order using ICD-9 or ICD-10 coding conventions. Next to each code, complete a narrative description of the code from the ICD-9 or ICD-10 CM code book. Place a check next to the diagnosis that is the primary diagnosis for this treatment episode. **DSM Diagnostic Codes**: Check if using DSM-IV or DSM 5 codes. List codes using DSM coding conventions. 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. **Note:** Providers should ensure familiarity with regulations governing who can diagnosis mental illness and adhere to state licensing laws as applicable.
Check Primary/ Billing Diagnosis	Check the primary/billing diagnosis.
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	**Child/Family/Guardian Expression of Services Preferences**
Service Preferences	It is important for the clinician and child, as well as his/her family or guardian, to have a meaningful dialogue to engage and allow the child and his/her family or guardian to express their treatment preferences and priorities. Identify the indicated needs/preferences of child/family/guardian for the full range of behavioral health clinical and community-based rehabilitative services, and environmental support services available to them.
Data Field	**Treatment Recommendations/Assessed Needs**
Treatment Recommendations / Assessed Needs	If, upon review of the most recent Child Comprehensive Assessment and the information from this update there are no additional recommendations or assessed needs, check the box **No Additional Recommendations Clinically Indicated**. If there are additional Treatment Recommendations/Assessed Needs the clinician, child and family/guardian should collaborate to identify and prioritize needs. These identified needs should be considered as the basis for subsequent treatment goals and/or objectives and all should be geared to improving the functioning of the child or reducing his or her signs and

	symptoms. ***Child Outpatient Example:*** Extensive testing; learn emotional regulation skills; decrease symptoms of anxiety and learn coping strategies; learn frustration tolerance skills; address peer interactions, communication and social skills
Child or Family/Guardian Declined/Deferred/Referred Out Rationale(s) (Explain why Child 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.
Data Field	**Further Evaluations Needed**
Further Evaluations Needed	Check the box(es) that identify additional assessment needs of the child (if any).
Data Field	**Was Outcomes Tool Administered?**
Was outcomes tool administered?	This is an optional field. Providers may choose to or have contract requirements relative to outcomes. Information pertaining to outcomes should be entered in this section. In some cases, the provider may wish to note the name of the instrument and most recent administration. The instrument and results may be located elsewhere in the medical record, however, this information should be used to assist in the development of treatment plan updates.
Data Field	**Level of Care**
Level of Care/ Indicated Services Recommendation	Recommend and record the least restrictive level of care that is safe for the child based upon the presentation of the child/family. The determination needs to be strongly supported by the symptoms, behaviors and skills deficits and abilities/needs documented in the earlier sections of the assessment or this update. Level of Care should be directly linked to medical necessity evidenced by the documentation throughout the assessment. Also, indicate the services within the Level of Care chosen to meet the identified clinical needs and the service preferences provided to the child /family. ***Child Outpatient Example:*** Outpatient level of care with emphasis on strong collaborations with outside providers identified as the result of testing; individual therapy, family psychoeducation and medication management services. If there is no change to the Level of Care/Indicated Services Recommendation, check the "No Change" box.
Data Field	**Response to Recommendations**
Child/ Family/Guardian Response to Recommendations	Record the child's/family's reactions and opinions to your recommendations in this section. You may record a summary or specific verbal responses provided by the child/family/guardian. Also record the child's and family's willingness to participate in treatment. If there was no change to the Level of Care/Indicated Services Recommendation above, check "Not Applicable".

Data Field	For Annual or Interim Updates
Change In IAP Required	If the assessed therapeutic needs can be supported by the Goals, Objectives, Interventions, services, frequency, duration and responsible provider(s) in the current IAP, then an IAP Revision/Review is not required. If the assessed treatment needs cannot be supported by the current IAP, then a change in the IAP is required. Please indicate the change by completing an IAP Revision/Review form.
Data Field	**Signatures**
Person's Signature (Optional, if clinically appropriate)	If clinically appropriate, record the legible signature of the person served.
Date	Record the date of signature.
Parent/Guardian Signature (if appropriate)	Record legible signature of the person's parent or guardian, if appropriate.
Date	Record the date of signature.
Clinician/ Provider - Print Name, Credential	Legibly print name and record legible signature of the clinician involved in the gathering and completion of the assessment. Record the educational level and the highest license level of the clinician involved in the gathering and completion of the assessment.
Date	Record the date of signature.
Supervisor Print Name/ Credential (If needed)	Legibly print name and record legible signature of the supervisor involved in the gathering and completion of the assessment. Some agencies may have policies requiring supervisor signatures on diagnostic assessments. Record the educational level and the highest license level of the supervisor involved in the gathering and completion of the assessment.
Date	Record the date of signature.
Clinician/Provider Signature	**Legible signature** of person completing the Assessment.
Date	Record the date of signature.
Supervisor Signature (if needed)	If required, legibly record supervisor's signature and credentials.
Date	Record the date of signature.
Psychiatrist/MD/DO Signature (if required)	Record legible signature of the physician involved in the gathering and completion of the assessment, if applicable.
Date	Record the date of signature.
Next Appointment Date/Time	Record the date and time of the person's next appointment.

Mental Health Status Exam

Data Field	Mental Health Status Exam
Person's Name	Record person's first, last name and middle initial. Order of name is at agency discretion.
Record Number	Record agency's established identification number for the child served.
Date of Admission	Record the date of admission.
Organization/Program Name	Record the organization/program for whom you are delivering the service.
DOB	Record the person's date of birth.
Gender	Indicate person's gender by checking the appropriate box. If checking "Transgender" box, also complete box of current gender designation for insurance purposes.
Mental Status Exam	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/clothing	Check appropriate boxes to describe physical appearance including clothing, 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 (in person's words)	Check boxes that apply. Emotional State-Mood is the 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. ***Child Outpatient Example:*** "I feel sad today". Also include a clinical assessment of mood. For example, Joel appears to be in a sad mood and anxious today. ***Adult Outpatient Example:*** Anxious
Emotional State-Affect	Check boxes that apply. Emotional State-Affect is the external expression of present emotional content. This describes the emotional state presently observed or described. ***Child Outpatient Example:*** Joel presents as sad and anxious with constricted affect. ***Adult Outpatient Example:*** Full range of emotional affect
___ WNL	Within normal limits
___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).
___Changeable	Demonstrated feelings shift rapidly from one state to another. Called changeable on the form.
___Inappropriate	Demonstrated feelings do not match with subject discussed (e.g. laughing while discussing a trauma experience).
___Flat	No reaction emotionally to situation.
___Full	Demonstrates a full range of feelings.
__Blunted, unvarying	Only slight reaction emotionally to the situation.
Facial Expression	Check boxes that apply.
Perception	
___ WNL	If there are no perceptual disturbances, check here

Hallucinations	Hallucinations are perceptions with a compelling sense of reality but occur 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.
___**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.
___**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.
___**Command****	Command hallucinations are voices telling someone to do something dangerous or harmful (e.g. "kill him").
Thought Content	
___ **WNL**	Check if thought content is within normal limits.
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; distrust
___**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."
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.
___**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.
__**Chaotic**	Totally disorganized, impossible to understand.
___**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?"
___ **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.
___ **Developmentally Disabled**	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:	
___**Time**	Does the person know what time and day it is (within a few hours)?
___**Place**	Does the person know where he or she is?
___**Person**	Does the person know his/her correct name, age and some facts about his/her life.
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?
___**Short attention span**	Person demonstrates difficulty staying on topic or attending to a task.
Insight	Check the most appropriate description of the person's current functioning.
___**WNL**	Check if the person's insight is within normal limits.
__**Difficulty acknowledging presence of psychological problems**	Reluctantly admits to minimal problems.

__**Mostly blames others for problems**	Projects blame for any problems onto others. Example: "They made me mad!"
__**Thinks he/she has no problems**	Denial of any problems.
Judgment	
___**WNL**	Decision making abilities appear intact and sufficient for day-to-day functioning.
Impaired ability to make reasonable decisions	Utilize scenarios to assess: 3. If you were in a crowded movie theater and noticed there was a fire off to the side in a hallway, what would you do? **4.** If you found a fully addressed and stamped envelope on the sidewalk, what would you do?
__**Mild**	Select if impairment to judgment is mild. **Example**: "Tell someone the building is on fire on the way out."
___**Moderate**	Select if impairment to judgment is moderate. **Example**: "Leave the building fast."
___**Severe****	Select if impairment to judgment is severe. **Example**: "Scream "fire" and run out."
Past attempts to Harm to Self or Others	Check the all boxes that apply and comment on all past attempts.
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**	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).
Comments	Add any necessary comments about findings from the MSE.
****	**Checking any item with ** requires an immediate risk and/or lethality assessment.**