Section 2

Using the MSDP Assessment Group Documentation Processes/Forms

This section provides a sample of each Assessment form type, guidelines for the use of each

PACT instructions: The Comp Assessment must be completed within 30 days of enrollment. The Comp Assessment must be redone every 12 months.

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Personal Information

The Personal Information Form has been created to demonstrate a minimum number of specific demographic data fields that need to be recorded for each person that will serve as a companion/top page for the Comprehensive Assessment form to provide specific information about the person. This form can be completed by support staff, clinical staff or some combination of the two as long as the form is completed on initial contact.

Data Field	Identifying Information Instruction
Time	Record the time of day.
Date	Record the date.
Caller	Check the appropriate box to identify who the caller is.
If "Other" What is the Relationship	If someone other than the person is calling, describe the relationship between the caller and the person.
Person's Name	Record the first name, last name, and middle initial of the person being served. Order of name is at agency discretion. Make sure that the caller spells the name.
Gender	Indicate person's gender by checking the appropriate box. If checking "Transgender" box, also complete box of current gender designation for insurance purposes.
Phone # Calling From	Record the phone number the person is calling from. Check N/A if walk-in.
Also Known As (AKA):	Record other names the person uses or has used in past, including maiden name(s)
Organization Name	Record the organization to which you are delivering the service.
Has Person Received Services Here Before	Check the appropriate box to determine if the person has received services here previously.
What has caused the person to seek services at this time?	Ask the person or caller to describe what has occurred at this time, why they are seeking services and record response.
Date of Birth	Ask and record the person's date of birth.
Age	Ask and record the person's age.
Social Security Number	Ask and record the person's social security number.
Best Phone Number to Contact	Ask and record the best phone number to reach the person. Ask and check the appropriate box if the person gives permission to leave a message at the identified number.
Secondary Phone Number to Contact	Ask if the person would like to offer a secondary contact number and record, including if ok to leave a message, if so indicated. If N/A- check this.
E-Mail Address	Ask if the person has an e-mail address and if they wish to communicate this way. If yes, record, including if it is ok to send a message. If N/A- check this.
Person's Address	Record primary address of person. If homeless, indicate.
Legal Guardian	Indicate the name of his/her parent, guardian, or custodian and his/her address and phone number. If the person is his/her own guardian, record "self".
In Case of Emergency Contact	Indicate the name, address, relationship and phone number of an emergency contact person.
Ask the Person, "Are you in a Dangerous Situation?"	Specifically ask the person or caller if the person is in a dangerous situation and check the appropriate box. If the person/caller reports yes, follow and document as per your emergency protocols.
Special Communication Needs	Ask and record whether or not the person is in need of special communication assistance. If none is needed, check the "none reported" box.
Special Physical Accommodations	Ask and record whether or not the person is in need of special physical accommodations. If none is needed, check the "none reported" box.

Ethnicity	Indicate the appropriate race by checking the indicators provided or indicate "unknown" if not able to determine race. Indicate ethnicity by checking appropriate category.
Primary Payer/Insurance Information/Authorizations	Complete all areas that apply for this section. Check the type of payment benefit/method the person has and indicate the respective benefit/plan number(s)/phone numbers. Complete all areas that apply related to initial authorization. Be sure to list the full name of authorizer and print neatly if entering manually. Complete secondary insurance information if person has another insurance benefit.
Determination	If the person is accepted, check the box and identify the service type (e.g., Intake) and scheduled appointment time/date if applicable. If the person is referred elsewhere, check the box and identify who/where the person was referred and why.
Person Served Preferences	This data field may be used to indicate a person's preference for a male vs. female therapist, morning vs. evening appointments or any other preference. Agencies will need to determine how this data field is used. **PACT:** Indicate preferences for where to meet, time to meet and if any concerns about gender staff with whom s/he will meet.
Schedule Time/Date (If Applicable)	If the person has been scheduled for an appointment, record the date and time of that appointment.
Staff Name, Date and Signature	The person who completes this form is to print and sign his/her name and identify the date of completion.

Adult Comprehensive Assessment

The Adult Comprehensive Assessment provides a standard format to assess mental health, substance use and functional needs of persons served. This Assessment provides a summary of assessed needs that serve as the basis of Goals and Objectives in the Individualized Action Plan. Some of the sections of the Adult Comprehensive Assessment may be completed by the person served prior to the initial intake evaluation. It is at the discretion of each individual agency whether they choose to incorporate this process into the intake evaluation or not.

If needed, agencies should use their own Functional Assessment to assess any needs that are not addressed in the MSDP Adult Comprehensive Assessment.

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 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.
Data Field	**Presenting Concerns (in Person's/Family's Own Words)**
Referral Source	Document the referral source.
Reason for Referral	Document the reason the person was referred for services, from the person's and the referent's point of view.
What Occurred to Cause the Person to Seek Services Now (Note Precipitating Event, Symptoms, Behavioral and Functioning Needs)	Record (in person's own words) precipitating factors as reported by the person served 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, as reported by the person served. ***Adult Outpatient Example:*** Mary reported that about a month ago when she was lying in her bed going to sleep, her heart began to beat quickly. She reported she began to have difficulty breathing, had a pain in her chest or her heart, and she "couldn't stop shaking." She stated that she was scared she was "going crazy." Mary stated that this experience "felt like it lasted forever." She called a friend to come over and stated later that many of her symptoms had lessened by the time her friend arrived. A couple of days later, Mary said she had another experience like this with similar symptoms during the day. Mary said both experiences started "without warning" and that she is "nervous that it might happen again." She reported that she has had particular difficulty falling asleep. ***CBFS Example:*** In the past year, Jean has worked diligently toward the goal of becoming her own rep payee. Now that she has achieved her goal and manages her own money, she is looking for assistance to establish her own apartment. "I just want to get out of this program and live on my own like a normal person," Jean explains. "I know I'm going to need some help to get started - especially with medications and getting a job." Jean had entered WSH in 2009 after an attempted suicide by overdose, which had been prompted by intense feelings of being overwhelmed, anxious and experiencing auditory hallucinations commanding her to kill herself. Prior to her WSH hospitalization, she had a one month hospitalization in 2006 at UMass 8 East prompted by auditory hallucinations, increased agitation and mood instability. She also spent approximately 4 months in 2000-2001 at the Sunrise House program after reporting suicidal thoughts, cutting her wrists and abusing substances. ***BSAS Example:*** Client was arrested for DUI which scared him. The DAE program referred him for further assessment at the Outpatient Counseling Program.
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). For example, if the person lives in supportive housing, check off that box and move to the next question. If applicable, you may check off more than one box (see example given below for Residential Care/Treatment Facility).

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. **PACT:** This may include intermediate care or medical or addictions rehab facilities.
At Risk of Losing Current Housing	Check yes or no. If yes, provide comments that illustrate the situation. **PACT:** If there is a risk of losing housing, the housing Specialist should be involved. Documentation should include any current or potential loss of subsidies and reason for risk at this time and if any previous interventions have been attempted and if the person wants to retain this housing option.
Satisfied with Current Living Situation	Check yes or no. If yes, provide comments that illustrate the situation. **PACT:** Discuss if the current living situation supports the person's goals and priorities, e.g. does it promote independence, provide access to transportation or preferred community as needed?
Comments	Add comments about the person's current living situation as necessary. Include environmental surroundings and neighborhood description.
Data Field	**Family History**
Family History and Relationships, Parental/ Familial Caretaker Obligations	Record details of what the person/guardian/parent and the interviewer identify as important facts regarding the person's family history and family relationships and parental/familial caretaker obligations. **PACT**: This section should be contributed to by all members. Include information about the feelings related to the family obligations. Include information on past and present family relationships. Include information about children, relationships with them, and goals for these relationships. Be sensitive to non- traditional families and the difference between biological vs. other people with parental rights or in parental roles. Provide names and ages and contact information for family members if there are releases. ***Adult Outpatient Example:*** Mary reported that she has two younger sisters, whom she speaks to "about once a month." She reported that her parents went through a "messy divorce" which ended when she was about 7 years old and that she is closer to her mother than her father at this time in life. She reported that most of her family lives in Virginia, where she grew up. Mary stated that she has been married to Paul for 8 years and has two children. She reported her daughter is 6 and her son is 3. Mary noted that she and her husband usually get along well, but have been having "some difficulties" in the past 6 months. She stated that she did not wish to talk about this further "unless it seemed necessary." ***CBFS Example:*** Jean states that her mother Maria is 52 years old. Jean states she is very close to her mother but explains, "my mom is overly involved in my life. She means well but usually treats me like I'm still a teenager." Jean stated that her father's name is Gerald but Jean has no memory of him. Jean explained that Gerald left the family shortly after the birth of younger brother (Edward) and Jean said, "I could care less if he's alive or dead." Edward is three years younger than Jean and lives in the house with Maria. Jean feels that her brother is supportive and she feels very close to him despite what she describes as "occasional sibling rivalry." Jean reports that she has never been married or had children. She babysits for her 9 year old female cousin Lily approximately once every three months when Lily's mother has to work second shift and cannot find alternate child care arrangements. Jean stated that she enjoys taking care of her cousin and would like to have a child of her own someday. ***BSAS Example:*** Robert is single, lives with single mother and younger siblings. Estranged biological father is a heavy drinker.
Pertinent Family Medical, MH and SU History	Include any identified family history of medical, psychiatric or substance use disorders. ***Adult Outpatient Example:*** Mary reported that her mother and two aunts are breast cancer survivors. She stated that her father has diabetes. She stated that no one in her family has "official" mental health concerns as far as she knows, though Mary suspected that some of her family members on her mom's side struggle with anxiety. Mary stated that her father "used to drink," but has "been sober for some time now." ***CBFS Example:*** Jean reported that her mother is diabetic and that heart disease runs in her mother's side of the family. Jean also stated that her mother described her father as "an alcoholic" and has reported that the paternal side of her family struggled with both alcohol and drug abuse. ***BSAS Example:*** Robert is a heavy drinker. His Paternal grandfather is as well. Mother's family has some history of bipolar disorder. Robert reports a family history of paternal grandmother having a stroke and reports various cancer illnesses among maternal family members.

Developmental History and Status	Record specific and pertinent physical developmental history you think may have an impact upon the current functioning of the person and its effect on the treatments and supports likely to be employed. Include speech/language, sensory/motor and cognitive deficits. Be sure to include any head injuries. Refer to Piaget's developmental stages for background. **PACT:** Be sensitive to gender preferences and orientation. ***Adult Outpatient Example:*** Mary reported she was held back in the first grade, but otherwise reported normal development. ***CBFS Example:*** Jean reported that she learned to walk and talk at an early age and did not appear to have any difficulty in school until she was in a car accident at the age of 10. Her head hit the dashboard and she was diagnosed with a concussion. Jean stated that after the accident, she struggled to concentrate and her grades began to drop significantly. Jean was on an IEP during the remainder of her school years and received special accommodations for due dates and alternate assignments in reading comprehension due to her concentration issues. "I just haven't been the same since the accident. Sometimes I get really angry because I used to be so smart," Jean stated. ***BSAS Example:*** Robert states he struggled in high school. He was a star athlete / football player and had suffered at least one incident of a concussion. Robert reports some use of performance enhancing drugs while in high school.
Data Field	**Social Support**
Friendship/Social/Peer Support Relationships, Pets, Community Supports/Self Help Groups (AA, NA, SMART, NAMI, Peer Support, etc.)	Describe the person's relationships with friends and other sources of social support. Describe social skills and limitations including difficulties the person may experience in his/her relationships with others. Record the supports the person currently receives from his/her community or from self-help groups. Include a description of the support(s) being received. For example, if the person is receiving support from the Department of Children and Families, explain what types of services DCF is providing. **PACT:** Include information and examples about the person's current level of community integration, e.g. are they a member of a church or other community; and their preferences for community integration, e.g. individuals or groups they define as their community or would like to have as their community. ***Adult Outpatient Example:*** Mary reported she has a couple close friends from nursing school, but not many other friends. She reported having no pets and not being involved in any self-help groups. ***CBFS Example:*** Jean reports that her brother is her closest friend and biggest support. "He's the first person I go to when something is going wrong in my life or when I feel my mood starts to slip," Jean explained. Jean noted that she used to have a boyfriend who she could turn to but they recently broke up. She also mentioned a close friend named Suzy who moved away last year with whom she has intermittent contact. Within the past 6 months, Jean has become involved with a group of individuals at the Recovery Learning Center (RLC) and would like to start seeing them socially outside of the RLC. Jean stated that friendships are largely a new experience for her because she has always been "shy and self-conscious" around new people. Jean often fears that people are "saying bad things about her behind her back," which makes it difficult for her to initiate new relationships. Jean reported that she used to drink alcohol and smoke marijuana often when she was a teenager and used to attend a sobriety support group in Marlboro called "Simply Sober." However, Jean stopped attending the group in her early 20's because she no longer felt that substance use was an issue. During her last hospitalization, she began attending AA groups and currently has an AA sponsor. She also attends the RLC and attends a variety of groups to assist her with symptoms of her mental health issues. ***BSAS Example:*** Current friends are all "partiers" and have used recreational drugs on weekends for as long as he can remember. He has not had a regular girlfriend since high school. "I have enough trouble taking care of myself" and states he does not need AA as "I am not one of those people".

Religion/Spirituality and Cultural/Ethnic Information	Record religious and/or spiritual issues important to the person and that may impact his/her mental health and/or substance use treatment and support needs. Spirituality may encompass belief in a "higher power" or connection to some other entity that helps him/her feel a sense of significance, peace, or belonging without religious rituals. Include belief systems about an afterlife, reincarnation, or basic assumptions about mankind or creationism. Describe how person served uses religion in his/her day-to-day life. **PACT:** Discuss with the person served its role in recovery and treatment, medication preferences, and possible support persons. ***Adult Outpatient Example:*** Mary reported that she began attending a church again in the past couple months. She described it as "a positive experience" for her and her children. ***CBFS Example:*** Jean reports that she was raised in the Jewish faith but she does not attend temple regularly. At one time, Jean stated that she felt very involved at Temple Emmanuel but has lost interest in participating over the years. She describes her family as "high holiday Jews," explaining that her family gathers for Rosh Hashanah and Passover. She also noted that her family gets together on the first night of Hanukah to light the menorah and open small gifts. Jean stated, "Every year I try to fast for Yom Kippur - sometimes I make it the whole day, other years I don't." ***BSAS Example:*** Robert reports he was raised in a Catholic home and currently goes to church when his mother makes him. Record cultural and ethnic issues considered important to the person and/or family and are pertinent to mental health and/or substance use treatment and support needs. Identify issues necessary to address to provide culturally competent treatment and support to the person. Also, note any relevant issues relating to immigrant status and/or assimilation into American culture. ***Adult Outpatient Example:*** Mary described herself as bi-racial (Caucasian/African American). ***CBFS Example:*** Jean reported that her family is of Jewish and Armenian descent. She feels pride in her Jewish roots, stating "even though I'm not that into the religious side, I do feel proud of my lineage." Jean explained that her father was Armenian and says, "I don't care about my Armenian side - the same way my father didn't care about me." Although Jean doesn't feel that she follows any particular cultural conventions, she stated that Rosh Hashanah is a particularly important holiday for her family. Jean also stated that she loves knishes, Italian and Thai food and "couldn't imagine life without it." ***BSAS Example:*** Robert's family is Irish and reports drinking as "a way of life".
Data Field	**Legal Status and Legal Involvement History**
Does person served have a Legal Guardian, Rep Payee, or Conservatorship?	Check the appropriate box. If *yes*, complete the Legal Status Addendum. **PACT:** This section should be completed by varied team members bringing their knowledge and perspectives based on their relationship and experience with the person. If the person has a guardian, the legal addendum must be completed. If there is a guardianship or rep payee, specify the outcome that is expected. Include a date to review whether it is still effective. Include information about the person's feelings regarding having a rep payee or guardian. Include information about the person's relationship with the rep payee or guardian.
Is there a need for a Legal Guardian, Rep Payee, or Conservatorship? Explain.	Note if assessment data indicates possible need for a Legal Guardian, Rep Payee, or Conservatorship by checking the appropriate box. Provide comments regarding the need, if appropriate. **PACT:** If there is a recommendation for guardianship or rep payee, specify the outcome that is expected. Include a date to review whether it is still needed.
Does the person have a history of, or current	Check the appropriate box. If *yes*, complete the Legal Involvement and History Addendum

involvement with the legal system (i.e., legal charges)**?**	
Data Field	**Education**
Education: PACT instructions	This section should be completed by the rehab/voc specialist. The Education Addendum is always required. Include in the addendum subjects that the person served liked, relationships with other students and teachers, any experiences of bullying, and experience with sports or other activities.
Highest Level of Education Achieved	Check the box that indicated the highest level of education achieved. Indicate the highest grade completed.
Person's Preferred Learning Style(s)	Check all boxes that apply, or indicate "other" and comment on how the person best learns new information.
Currently Enrolled in an Educational Program?	Check the appropriate box. If yes, complete the Education Addendum.
Is the person interested in further education or assistance in education?	Check the appropriate box. If *yes*, complete the Education Addendum.
Data Field	**Employment and Meaningful Activities**
Employment and Meaningful Activities: PACT instructions	This section should be completed by rehabilitation/vocational specialist. Include observation of preferences, such as favorite music, or television shows, favorite subject or sports. The PACT Employment Addendum is always required and completed by the Employment Specialist. Include information about potential references from previous experiences, as well as positive and negative specifics about previous experiences. Include if school or other coursework may be of interest. Document how the person spends their day (i.e. favorite TV shows, internet sites, library, volunteering, time with friends/ family, hobbies)
Employment Status/Interests	Check all boxes that apply. Comment on any specific issues/skills identified.
Does the person want help to find employment or vocational training?	Check the appropriate box. If yes, complete the Employment Addendum.
Meaningful Activities (Community Involvement, Volunteer Activities, Leisure/Recreation, Other Interests)	Record meaningful activities that the person participates in.
Data Field	**Income/Financial Support**
How does the person describe her/his current financial situation?	Check the appropriate box. Provide comments where indicated/applicable.
Does the person receive any sources of financial assistance?	Check all boxes that apply to record the person's income/financial support situation. If yes, specify type and amount. **PACT:** If person is a veteran, ask "Have you investigated any benefits from service time available to you? Medical, prescription, payments?" Document in OTHER or Type and Amount.

Data Field	Military Service
None Reported	If person reports no military service history, check None Reported and skip to next section.

Military Status	Check the appropriate box. **PACT:** If military experience is reported, inquire about the person's entitlement to any medical, prescription or payment benefits. Document the response in the Income/Financial Support section under other. Document the report of the experience on the employment addendum.
Date of Discharge	Document the date the person was discharged from service.
Type of Discharge	Check the box that applies and comment on reason(s) for Other than Honorable, Bad Conduct, or Dishonorable discharge.
Is a complete Military Service assessment needed?	Check the appropriate box. If *yes*, complete the Military Service Addendum.
Data Field	**Addictive Behavior and Substance Abuse History**
Does person report a history of, or current, substance use or other addictive behavior concerns (i.e. alcohol, tobacco, gambling, food)?	At a minimum, a basic screening instrument (e.g. CAGE, MAST, DAST) should be administered in addition to person's self report and information available from other sources. It is up to the individual agencies as to which screening instrument to use. If there are no substantial indications for substance use or addiction problems past or present check *No* and skip to the next section. If *yes*, complete the Addictive Behavior History/SA Addendum. **PACT:** The Addictive Behavior History/SA Addendum is always required if the person is or was a substance user. The ASAM is not required. Assessment should include the person's experience with 12 step meetings, sponsors and the person's assessment of their helpfulness. Addendum should be completed by the Substance Abuse specialist or others assigned. Specify time frames covered by the questions. Document additional information regarding the type of program; which worked best and why and/or what did not work and why. Include timeframes.
Data Field	**Mental Health and Addiction Treatment History**
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.
Inpatient/Outpatient	Record the type of treatment.
Completed?	Check if person completed the originally planned service. **Example: Check *No* if person discharged himself against doctor's orders.**
Efficacy of past and current treatment	Indicate if treatment was helpful and explain why the person thinks it was or was not helpful.
Psychiatric History (include past diagnosis and course of illness)	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.
Source(s) of Information:	Indicate the where information on the person's mental health service history came from by checking the appropriate box(es).
Data Field	**Physical Health**
PCP, Medical Specialist and Dentist Name, Credentials, Specialty	Record the person's PCP, Medical Specialist providers (if applicable) and Dentist's names and credentials. The PCP may be a RNP or Pediatrician but must be the medical professional primarily in charge of the person's overall physical health care. **PACT:** The physical health assessment should be completed. This section should refer the reader to the physical health assessment. It should be completed by a Nurse. The pain assessment should include where in the body if pain is reported. If pain is reported there should be recommendations/referrals related to pain relief. Be sure to explore both medical and other recommendations such as acupuncture, herbal tx, etc.

	Be sure to note chronic conditions. Incorporate management, education, and impact of the illness into the treatment plan.
Telephone Number	Record the person's PCP's, Medical Specialist's, and Dentist's telephone number(s).
Fax Number	Record the person's PCP's, Medical Specialist's, and Dentist's fax number(s).
Address	Record the person's PCP's, Medical Specialist's, and Dentist's address(es).
Date of Last Exam	Record the date the person last received a physical, an exam by his/her specialist, and dental exam (approximate if necessary).
Data Field	**Physical Health Summary** (or Refer to Attached Physical Health Assessment) **(Bureau of Substance Abuse Services (BSAS) Programs must complete the MSDP Infectious Disease Risk Addendum and the BSAS TB Assessment)**
Allergies	List all known food, medication (including OTC, herbal) and environmental allergies for the person. Note drug sensitivities. If no allergies/drug sensitivities are known, check *No known allergies* and skip to next section. If yes, list below.
Physical Health Summary	Summarize physical health history including chronic conditions, current physical complaints or dental issues that may interfere with the person's functioning or ability to attend and benefit from treatment. If there are significant health issues, check *Refer to Attached Physical Health Assessment* and complete or include that document to provide necessary details.
Does the person use complimentary health approaches (e.g. natural products, mind-body practices, yoga)?	Indicate if the person utilizes any complimentary health approaches. If yes, describe.
Does the person wish to consider using complimentary health approaches and want help finding a provider	Indicate if the person would like to consider using complimentary health approaches and/or if they would like help finding a provider. If yes, describe.
Sexual History/Concerns	Record pertinent sexual history information identified by the person, parent/guardian or interviewer. Address topics such as concerns/questions about sexual orientation or gender identity; age of first sexual encounter; number and history of sexual partners; fetish behavior; other behavior interviewer may consider relevant based upon training or agency policies.
Data Field	**Pain Screening**
Does the person experience pain currently	Indicate yes or no whether the person reports experiencing any current pain.
Has the person experienced pain in the past few months?	Indicate yes or no whether the person reports experiencing any pain in the last few months.
Describe the type, frequency, duration, intensity, identified cause, any limitations to functioning and what helps relieve the pain.	Indicate the type, frequency, duration, intensity, identified cause, any limitations to functioning and what helps relieve the pain.
Data Field	**Nutritional Screening**
Nutritional Screening	Check all that apply. Include a description of the person's beliefs perceptions, attitude, and behaviors regarding food.

Data Field	Medication Summary
Medication information and history of adverse reactions	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 list all other information the person remembers. This is especially important for current medications that the person is taking. Include what medications work well and have worked well previously, any adverse side effects, why person doesn't take medication as prescribed and/or which one(s) the person would like to avoid taking in the future. **PACT:** This section should be completed with by the PACT MD and others team members based on their experience with the person as assigned by the Team Leader. Always complete the Medication Addendum if the person has been taking meds or OTC supplements within the past 3 years. Add information indicating if the medications were effective or not effective, and for which symptoms? Include information indicating if the medication was effective or not effective and for what symptom? Add information about what kind of supports or prompts are helpful to the person to maintain a medication regimen. Add information regarding the person's feelings about taking medication and any use or intention to pursue alternative therapies.
Is the person served currently taking any medication?	Check the appropriate box. If *yes*, complete the Medication Addendum. **PACT:** See above. Team Leaders must insure there is a procedure and person assigned to insure this is updated

Data Field	Advanced Directive
Does the person have advanced directive established	Note here if the person served had any Advanced Directives in place and if yes, choose which type(s). If there are no Advanced Directives currently in place, note if the person desires to establish Advanced Directives and then refer to the agency's procedure for completion. **PACT:** This section should be completed by the person assigned as the person served Primary case manager. Return to complete this section at different points in the relationship. There may not be the information needed at intake about the relationships the person has with other supports or guardians. The person may not have the relationship with the PACT team to explore this. Further experience with the person may be required to know what may or may not be options may be needed.
Data Field	**Trauma History**
Does person report a history of trauma?	Check the appropriate box. If *yes*, complete the Trauma History Addendum. **PACT:** All team members should contribute to this section. Use this section for formulation and treatment planning. Always complete this from records. Assume a trauma history. Add to a trauma addendum as information becomes known. The Trauma is defined by the person's experience of the events. Trauma may include commitment, incarceration, loss of children, foster care, and experiences around guardianship, natural disasters, and persistent oppression.
Does person report history/current family/significant other, household, and/or environmental violence, abuse or neglect or exploitation?	Check the appropriate box. If *yes*, complete the Trauma History Addendum.
Data Field	**Mental Status Exam**
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, 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. ***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. ***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**	Is the person able to focus and stay on topic for extended periods of time?
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: 1. 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? 2. 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.**
Data Field	**Person's Served Strengths/Abilities/Resiliency** (Skills, Talents, Interests, Aspirations, Protective Factors)
Personal Qualities	Describe the personal qualities (strengths/capabilities), as identified by the client and the clinician that can be put into service toward achievement of the person's goals. **PACT:** This section should be completed at an all staff team meeting and used in treatment planning meetings. ***Adult Outpatient Example:*** Mary had difficulty identifying her strengths when first asked. During this evaluation, Mary described ways she cares for others professionally and personally. Mary reported that she is a good singer. She reported being willing to be a part of treatment at this time. ***CBFS Example:*** Jean is a polite, energetic and enthusiastic individual. Jean stated she "has a talent for drawing birds and mimicking bird calls." She has also stated that she would like to "find her true love, get married and have a kid." ***BSAS Example:*** Robert states he is not currently satisfied with his life and has a strong desire to make changes toward a more independent and positive life situation.
Living Situation	Describe the person's strengths and capabilities regarding his/her daily living situation. Record the community resources available to the person. ***Adult Outpatient Example:*** Mary reports she has been able to maintain stable housing**.** ***CBFS Example:*** Jean has stable housing at the Alsada program and has been learning independent living skills over the past year. She is very motivated to move out of the Alsada program and live on her own. She also has supportive family members who assist her with emotional and financial needs. ***BSAS Example:*** Robert currently lives with his mother and younger siblings. His family has minimal resources and he contributes money when he has it. He feels safe in his environment

	and reports having excellent daily living skills.
Financial/ Employment/Education	Describe the person's strengths and capabilities regarding his/her financial situation. ***Adult Outpatient Example:*** Mary reports only occasional struggles with finances. Mary reports she has been employed as a nurse in her current position for 8 years. ***CBFS Example:*** Jean spent the past year learning how to budget her current income and pay her own bills, resulting in Jean becoming her own rep. payee. Jean stated, "School wasn't my strength after the accident but I was determined to get my diploma so I kept pushing myself through school until I got it." Jean is interested in finding work related to nature and is strongly interested in pursuing this work. She also has a strong interest in running and is working with a running coach in the hopes of running marathons competitively. ***BSAS Example:*** Robert is a landscaper in the summer and plows snow on occasion in the winter. He works under the table. He has extra cash in the summer and barely any in the winter. He has taken a few classes at the local community college and is currently registered for one class. He has considered becoming a teacher and would like to coach a high school football team.
Health	Describe the person's strengths and capabilities regarding his/her health. ***Adult Outpatient Example:*** Mary reports that she regularly discusses medical concerns with her doctor and sees this as a supportive relationship. ***CBFS Example:*** Jean is in great health and generally chooses healthy foods. She stated, "My mom is diabetic so I really have to be careful about what I eat or else I could end up with diabetes too." ***BSAS Example:*** Robert reports having no health concerns and considers himself in "excellent health."
Leisure/Recreational/ Community Involvement	Describe the person's strengths and capabilities regarding his/her leisure/recreational skills and community involvement. ***Adult Outpatient Example:*** Mary reports that she is considering singing at her church, an activity she has previously enjoyed. ***CBFS Example:*** Jean enjoys running and is training to run in marathons. Jean expressed her love of nature and she frequently goes out on long walks in the woods. She also enjoys bird watching, where she is able to use her skill in bird calls. She loves gardening and volunteers at the Regional Environmental Council in their urban garden during the spring and summer. Jean has recently been attending the RLC in her spare time and has made friends with several of the other group attendees. ***BSAS Example:*** Robert reports "I wish there was more to do in New Bedford than go to bars on Friday and Saturday night".
Natural Supports	Describe the person's natural supports, such as family members, clergy, close friends, neighbors, and advisors. **Adult Outpatient Example**: Mary reports having a couple of close friends from nursing school. She reports being in contact with her sisters on a monthly basis.
Spirituality/Culture/ Religion	Describe the person's strengths and capabilities regarding his/her spirituality, culture and/or religion. ***Adult Outpatient Example:*** Mary reports she has recently become involved in a local church, which she has found encouraging. ***CBFS Example:*** Jean feels pride in her Jewish heritage. Although she does not consider herself strongly involved in the Jewish religion, she notes that several religious holidays bring the family together. Her family gathers to celebrate Rosh Hashanah, Passover and Hanukah. She also attempts the fast on Yom Kippur every year. ***BSAS Example:*** Robert reports he is not an active church goer, and goes to Catholic church when his mother makes him.

Data Field	Assessed Needs Checklist Including Functional Domains
Check Current Need Areas (CN) and Check areas where Person Desires Change Now (PD)	Current Need Areas will be based on the assessment. 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 Family and Social Support Legal Employment/Education/Finances Addictive Behaviors and Substance Use Mental Health/ Illness Management and Behavior Management Physical Health Risk Other Needs Areas Areas where person desires change now will be used to generate the Prioritized Assessed Needs. **PACT**: The Team Leader can assign sections to any team member depending on the person's needs and preferences. The peer Specialist can be considered an option for any section as appropriate. The recommendations for assignment are below and identified in different sections of the instructions. ADLs-can be completed by any team member. Family should be completed by Primary. Include the person's feelings related to the family obligations, include past and present relationships, incl. information about children, parents and other family members and information about these relationships and the person's goals for these relationships. Include information about level and preferences for community integration. Legal- should be completed by varied members. Addiction should be completed by the addiction specialist. Mental Illness Management should be completed by the Primary. Risk assessment should be completed by Primary and Team Leader with input from the Peer Specialist and MD If high risk behaviors are presenting as a Current Need more detailed information must be provided in the narrative section and the interpretative summary. The Peer Specialist's perspective should be considered in identifying the assessed needs.
Current Needs Selected Above 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.
Data Field	**Clinical Formulation - Interpretive 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 narrative summary and 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). 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 who should complete the Interpretive Summary **PACT**: The Interpretative Summary is assigned by the Team Leader. It is reviewed by the Team Leader or Lead Clinician It should integrate information from the full assessment, the assessed needs sections, other sources of information and team dialogue. If a crisis plan was developed in the past, there should be information regarding its

	effectiveness in preventing crisis. The summary should describe the person's resilience and coping strategies they have used before coming to the attention of DMH. It should describe what is happening in the person's life to that requires a PACT referral or PACT services at this time.
Data Field	**Further Evaluations Needed**
Further Evaluations Needed	Check the box(es) that identify additional assessment(s) needed for the person (if any).
Data Field	**Was Outcomes Tool Administered?**
Was outcomes tool administered?	Note if a standardized outcomes tool was administered for this person. This may include the TOPS instrument for MBHP and BC/BS or other tools such as the Basis-32.
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-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.
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	**Prioritized Assessed Needs as Evidenced by**
Prioritized Assessed Needs	The information for this section comes from the Assessed Needs Checklist. Identify and record *Assessed Needs* of the person/person's guardian, if applicable. In some cases there may be high need areas that cannot be deferred without risk to the person 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 person in life roles or reducing the symptoms of his/her illness. **PACT:** Deferred Needs should be revisited regularly, not only at the 6 or 12 month review. The mini – team should initiate this as well as the primary. Family and Social Supports: Be specific about needs related to childcare. Mental Illness and Management: Include conflict resolution skills, self- care skills, problem solving skills, time "management "skills and any issues related to literacy. If there is a diagnosis of "antisocial" describe the behavior and responses that may be problematic for the person in light of their goals. Include trauma related responses such as dysregulation and hyperarousal. Differentiate between a symptom and a preference, especially around ADLs. Example: if person has piles of laundry, who decides that it is a need area if the person is not bothered by it? Keep in mind that the solution would be different depending on the reason. For example, the solution could be a regular laundry service. If you discover the laundry avoidance is due to anxiety then therapy/coping skills may be helpful. The person may still choose the laundry service. High Risk Behavior: If anything is noted, a risk addendum is required. ***Adult Outpatient Example:*** 1. Mary needs to find ways to understand and better manage her

	panic attacks and anxiety. 2. Mary needs to improve her physical health (including managing her weight and considering quitting tobacco use per her doctor's recommendations). 3. Mary may need additional support or skills in her marital relationship. ***CBFS Example:*** **Activities of Daily Living -** Employment, Housing, Medication Management Money Management**-Active** **Activities of Daily Living-** Transportation, Family/ Social Support, Peer/ Personal Support Network**-Deferred** **Mental Health/ Illness Management -** Anxiety, Coping/Symptom Management-**Active** **Mental Health/ Illness Management -** Disturbed Reality (hallucinations), Trauma-**Referred Out** **Risk/ Safety -** Suicidal Ideation**,** Addictive Behaviors- Substance Use-**Person Denied** ***BSAS Example:*** Robert has disclosed that he occasionally "snorts" heroin. It is recommended that his substance use disorder be assessed to learn the extent of his use and work towards eliminating his opiate use. At the same time, work on increasing his awareness of his social milieu and work towards building healthier social relationships and activities. Assess all Recommendations/Needs as ACTIVE, PERSON DECLINED, DEFERRED, or REFERRED OUT. Include rationale for all Declined, Deferred and Referred Recommendations/Needs.
Person Declined/Deferred/Referred Out Rationale(s) (Explain why Person 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 to decline a recommendation at this time. If none from above are declined, deferred or referred out, check None.
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 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. ***Adult Outpatient Example:*** Individual outpatient treatment recommended. Begin with weekly sessions and move to every other week as appropriate ***CBFS Example:*** Jean would benefit from the assistance of the Richmond Support Housing program to provide her with support in the community while promoting her individual recovery process. ***BSAS Example:*** Robert is being recommended for Outpatient Group counseling / therapy to gain from group/community support. In addition, Robert may benefit from seeking a medical doctor to prescribe a Medicated Assisted Treatment, such as Suboxone to address any desire to use opiates. *****Note: For organizations without formal levels of care, list the services that are being recommended.
Person Served/Guardian/ Family Response to Recommendations	Record reactions and opinions in this section. You may record a summary or specific verbal responses provided by the person served/family/guardian. Should record the client and family's willingness to participate in treatment. ***Adult Outpatient Example:*** Mary reported being eager to begin treatment. She stated that she was unsure what was leading to her "episodes," but she wanted to do what she could so that they wouldn't happen again.

	CBFS Example: "I am really excited to work on moving out on my own - I'm just worried about how my mom will react." ***BSAS Example:*** Robert's family is not currently involved in the treatment plan. "I do not want to cause more problems for my mom".
Data Field	**Signatures**
Person's Signature (Optional, if clinically appropriate)	Signature of the person 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.
Parent/Guardian Signature (if appropriate)	Record legible signature of the person's parent or guardian, if appropriate.
Date	Next to each signature record the date of the signature.
Clinician/Provider – Print Name/Credential and title	Legibly print name and credential(s) of person 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 printed 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.
Clinician/Provider Signature	**Legible signature** of person completing the Comprehensive Assessment.
Date	Next to each signature record the date of the signature.
Supervisor Signature (if needed) see also MDT requirements for day treatment and signatures.	If the diagnosis is rendered by a clinician other than the clinician signed above, then the clinician rendering the diagnosis must provide his/her signature and record his/her educational level and highest license level.
Date	Next to each signature record the date of the signature.
Psychiatrist/MD/DO (if required)	This is a requirement for Opiate Treatment Programs.
Next Appointment / Date / Time	Record the next appointment for the person including date and time.

Comprehensive Assessment Update - Adult 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 diagnostic assessment portion of the person's record. In all cases, provider agencies should determine whether the new/additional information contained in this form requires an updated Individualized 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. This form does not replace existing formats for original evaluations/assessments. Completion of a Comprehensive Assessment Update form does not necessarily assume billing of a diagnostic 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.

PACT Mini-team: Mini- teams are documented on the Comp. Assessment Update form.

Mini-team instructions:
Check the Interim Update of New Information box on the PACT progress note.
Narrative- describe the incident or information necessitating the mini- team and provide narrative for each assessment update and the plan to address it.
Include planned interventions and persons responsible.
Complete preferences as applicable.
Complete level of care section and client /guardian response section as applicable.
ASAM and Diagnosis are not required.
Indicate if an IAP revision is required.
Complete Assessed Needs Section, as applicable.

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 to 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-	Check the appropriate box to indicate whether the Update is:

Admission and Interim Update of New Information	• an Annual Update of the Comprehensive Assessment (if required by agency policy and procedures and/or accreditation), • a Re-Admission Update for a person 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 person 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 Original CA and Sections**
Date of Most Recent Comprehensive Assessment	Enter the date of the last Comprehensive Assessment in the chart
Adult Comprehensive Assessment Sections for Update	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 Licensed Clinician did not obtain the information above)	If the above sections are completed by an unlicensed staff person (e.g., unlicensed clinician, CSP Outreach Worker), the person 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	**ASAM Degree of Severity at Admission for the Following Dimensions (SU Persons served only)**
Dimension	The following websites provide additional information on the use of the ASAM matrix: http://www.asam.org/PatientPlacementCriteria.html http://mass.gov/dph/bsas http://www.neias.org/
Intoxication/Withdrawal Potential	Record severity on a scale of 0 (None) to 4 (Severe)
Biomedical Conditions/Complications	Record severity on a scale of 0 (None) to 4 (Severe)
Emotional/Behavioral/ Cognitive	Record severity on a scale of 0 (None) to 4 (Severe)
Readiness to Change	Record severity on a scale of 0 (None) to 4 (Severe)
Relapse/ Continued Use Potential	Record severity on a scale of 0 (None) to 4 (Severe)
Recovery Environment	Record severity on a scale of 0 (None) to 4 (Severe)
Family Functioning (Youth Only)	Record severity on a scale of 0 (None) to 4 (Severe)
Data Field	**Section II: Diagnosis Change**
Diagnosis Change- This section must be	If there is any change or addition to the diagnosis, this section should be used to record a full diagnostic picture including any changes to diagnoses using the following instructions.

completed by a qualified provider	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 diagnose 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	**Person Served/ Family/ Guardian Expression of Service Preferences**
Service Preferences	It is important that the clinician engage in a meaningful recovery focused dialogue with the person (and/or primary support person) which allows the person (and/or primary support person) 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 areas covered in the Assessed Needs. 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.
No Changes	Check if there have not been changes in service preferences.
Data Field	**Assessed and Prioritized Needs Checklist Including Functional Domains**
Assessed and Prioritized Needs Checklist Including Functional Domains	If, upon review of the most recent Adult 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, person served and others involved with the person, including family as appropriate, 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 person or reducing his or her signs and symptoms. **Examples**: • **Decrease symptoms of depression** • **Reduce suicidal ideation** • **Education about illness and treatment options** • **Enhanced management of active symptoms** • **Medication stabilization** • **Reduction of anger episodes** • **Development of symptom management skills**

Person Declined/Deferred/ Referred Out Rationale(s) (Explain why Person Declined to work on Need Area; List rationale(s) for why Need Area(s) is/are Deferred or Referred Out)	Describe reasoning behind worker's decisions to defer or refer out work on any assessed needs. Also provide reasoning behind decisions by person served to decline a recommendation at this time.
Data Field	**Further Evaluations Needed**
Further Evaluations Needed	Check the box(es) that identify additional assessment(s) needed for the person (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	**Further Evaluations Needed**
Further Evaluations Needed	Check the box(es) that identify additional assessment(s) needed for the person (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	**Services and Supports Needed**
Level of Care/ Indicated Services Recommendation	Recommend and record the least restrictive level of care that is safe for the person based upon his or her current clinical presentation. This recommendation needs to be strongly supported by the symptoms, behaviors, skills deficits and abilities/needs documented in the earlier sections of the assessment or this update. The 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 person/family. ***Adult Outpatient Example:*** Individual outpatient treatment recommended, every other week. ***CBFS Example:*** Jean would benefit from the assistance of the Richmond Support Housing program to provide her with support in the community while promoting her individual recovery process. If there is no change to the Level of Care/Indicated Services Recommendation, check the "No Change" box.

Data Field	Response to Recommendations
Person Served/Guardian/ Family Response to Recommendations	Record person's reactions and opinions to your recommendations in this section. You may record a summary or specific verbal responses provided by the person served/family/guardian. Record the person's and/or family's willingness and ability to participate in treatment. If there was no change to the Level of Care/Indicated Services Recommendation above, check "Not Applicable".
Data Field	**Change in IAP Determination**
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.

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/Program Name	Record the organization /program to which you are delivering the service.
DOB	Record the child'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	**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 Precipitating Event, 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 hospitalization due to feeling suicidal, factors would include: "I have had suicidal feelings for 5 days, I've cut myself in the 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 DCF Caseworker's name. Complete Legal status Addendum if person needs a guardian.
Is there a Rep Payee?	Check the appropriate box. If yes, complete the Rep Payee section of the Legal Status Addendum.
Is there a Conservatorship?	Check the appropriate box. If yes, complete the Conservatorship section of the Legal Status Addendum.
Is there a need for a Legal Guardian, Rep Payee, or Conservatorship that has not been met?	Check the appropriate box and provide comments regarding the need for a Legal Guardian, Representative Payee, or Conservatorship if needed.

Data Field	Instructions for Integration with CANS Assessment
Current Status is either captured below or in CANS Assessment.	If CANS Assessment has been completed, check box. If you have completed the CANS you do not need to complete the **current** information for those areas noted with an * if the current status is well documented in the CANS narrative. If you have not completed the CANS, complete all the following information. Comment should be included for any CANS score above a 1.
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).
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.
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.
Is Person 14 ½ years or older?	Check yes or no. If yes, complete Transition to Adulthood Addendum.
Data Field	**Family**
Family Functioning/Parent and Child Interaction/Relationship Permanence: Include the child functioning within the context of his/her family and community.	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).
Current Status	Record significant history regarding Family Functioning. (if CANS assessment not completed)
History	Describe current status of the Family Functioning.
Data Field	**Developmental Information**
Developmental/Cognitive Delay and Functioning/Sensory/Motor/ Sleep/Feeding Disorders: Include if child met developmental milestones and developmental/cognitive delay such as low IQ or developmental disability	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	Record current status of developmental milestones achieved or delays in attainment
History	Record significant history regarding developmental milestones achieved or delays in attainment
Learning Style (visual, auditory, verbal, written, or learn by doing)	Describe how the person best learns new information.
Current Status	Describe the current status of the person's learning style. Include if person has identified or suspected learning disabilities.

History	Record significant history regarding the person's learning style.
Learning Disability/ Communication, Comprehension and Expression: Include expressive and receptive language problems	Record significant history regarding learning impairments. Include information on preferred learning style.
Current Status	Record current status of learning impairments (if CANS assessment not completed).
History	Record significant history regarding learning impairments (if CANS assessment not completed).
School: Preschool/Childcare/Behavior/ Achievement/Attendance: Provide information based on age of child if older than preschool. Include current grade	Record significant history regarding school behavior, academic achievement, and school attendance and absences. Include if child is on a 504 Plan or IEP.
Current Status	Record current status of school behavior (if CANS assessment not completed), current level of student's academic achievement (if CANS assessment not completed), and current status of school attendance or absence.
History	Record significant history regarding school behavior, academic achievement, and school attendance or absence.
Self-Care: Include whether child can perform age appropriate activities of daily living, assistive technology and special communication needs and ability to self-preserve	Record significant history regarding self-care skills (for example toileting, grooming, eating, brushing teeth, showering, etc.).
Current Status	Record current status of self-care functioning (if CANS assessment not completed). Include assistive technology and special communication needs. Include ability to self-preserve.
History	Record significant history regarding self-care skills (for example toileting, grooming, eating, brushing teeth, showering, etc.).
Data Field	**Cultural and Religious Considerations**
Language (Primary Language and Secondary 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	Record current status of child's language (s) (if CANS assessment not completed).
History	Record significant history regarding language.
Cultural Differences Within a Family	Record noted cultural differences with the family that may impact the child and treatment.
Current Status	Record Current status of the cultural differences. (if CANS assessment not completed)
History	Record significant history of the cultural differences.
Cultural/Ethnic 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	Record current status of child's cultural identity (if CANS assessment not completed).

History	Record significant history of the person's cultural/ethnic identity. (if CANS assessment not completed)
Discrimination/Bias	
Current Status	Record current status of discrimination/bias (if CANS assessment not completed).
History	Record significant history of the person's discrimination/bias.
Religion/Spirituality	Record religious and/or spiritual issues important to the person and that may impact his/her mental health and/or substance use treatment and support needs. Spirituality may encompass belief in a "higher power" or connection to some other entity that helps him/her feel a sense of significance, peace, or belonging without religious rituals. Include belief systems about an afterlife, reincarnation, or basic assumptions about mankind or creationism. Describe how person served uses religion in his/her day-to-day life. ***Child Outpatient Example:*** Joel's values and beliefs are connected to an organized religion.
Current Status	Record current status of Religion/Spirituality, (if CANS assessment not completed)
History	Record significant history of the person's Religion/Spirituality.
Youth/Family Relationship to System	Record details of what the person/guardian/parent and the interviewer identify as important facts regarding the person's family history and family relationships. ***Child*** ***Outpatient Example:*** Joel is a first generation Dominican/American born to Dominican parents. He and his parents attend church weekly and participate in church-related activities.
Current Status	Record current status of Youth/Family Relationship to system, (if CANS assessment not completed)
History	Record significant history of the person's Youth/Family Relationship to system.
Agreement About Strengths and Needs	Record current status of strengths and needs (if CANS assessment not completed)
Current Status	Record current status of strengths and needs, (if CANS assessment not completed)
History	Record significant history of strengths and needs (if CANS assessment not completed)
Data Field	**Social Support and Functioning**
Social Support, Social Functioning and Recreation/Play (Friendship/Social/Peer, Support Relationships, Afterschool Programs/Clubs, Pets, Community Supports/Self-Help Groups such as AA, NA, NAMI, Peer Support, etc.)	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. Include difficulties with social skills and relationships with peers and adults and child's ability to play appropriately with peers.
Current Status	Describe current status of social skills and relationships.
History	Record significant history regarding social skills, communication issues and relationships.
Community Functioning	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	Record current status of community functioning (if CANS assessment not completed).
History	Record significant history of community functioning (if CANS not completed).

Data Field	**Employment (complete if 14 years of age or older)**
Employment Income/Financial Support	**Check the appropriate box.**
(If not currently employed) **Person served wants to work?**	**Check the appropriate box.**
Does the person want help to find employment or vocational training?	Check appropriate box. Add comments if applicable. If yes, complete Employment Addendum.
Income/Financial Support (sources of and adequacy of financial support; own and /or parents/family)	Describe the sources and adequacy of the person's financial support(s), include his/her own as well as parents/family and other sources.
Data Field	**Caregiver Resources and Needs**
Medical/Physical/Mental Health and Substance Abuse	Include any identified family history of medical, psychiatric or substance use disorders. *Child Outpatient Example:* Mother treated for depression. Family history of heart disease and diabetes.
Current Status	Record current status of any Medical/Physical/Mental Health and Substance Abuse issues in the family.
History	Record significant history of any Medical/Physical/Mental Health and Substance Abuse issues in the family.
Developmental/Cognitive Delay	Record specific and pertinent physical development or developmental history about the Caregiver that you think may impact on the current functioning of the person served and its effect on the treatments and supports likely to be employed. **Child Outpatient Example:** Joel's mother does not have any cognitive or developmental delays that would impede her from providing appropriate parental guidance to her son. Had Joel's mother had any cognitive or developmental issues, you could write: Due to Joel's mother having developmental delays, additional resources will be needed to help her in following through with tasks i.e. family partner, parent aid).
Current Status	Record status of Caregiver's current developmental or cognitive delay
History	Record significant history of any developmental or cognitive delay of Caregiver
Family Stress/Housing Stability/Financial Resources/Organizational Skills/Advocacy/ Involvement	
Current Status	Record current status of any Family stress, housing stability issues, financial resources, organizational skills, advocacy and involvement.
History	Record significant history of any Family stress, housing stability issues, financial resources, organizational skills, advocacy and involvement.
Child/Youth Supervision	
Current Status	Record current status of the Child/Youth supervision.

History	Record significant history of child/youth supervision issues.
Data Field	**Legal Involvement History**
Does the person have a history of, or current involvement with the legal system (i.e. legal charges)?	Check yes or no. If yes, complete and attach the Legal Involvement and History Addendum.
Data Field	**Trauma History**
Does the person report a history of trauma?	Check appropriate box. If yes, complete the Trauma History Addendum.
Does the person report history/current family/relevant other, household, and/or environmental violence, abuse or neglect or exploitation?	Check appropriate box. If yes, complete the Trauma History Addendum.
Data Field	**Addictive Behavior and Substance Abuse History**
Does person report a history of, or current, substance use or other addictive behavior concerns (i.e. alcohol, tobacco, gambling, food)?	Check yes or no. If yes, compete the following based on the requirements of your program, funder, or organization.
Check other assessments completed	
Data Field	**Mental Health and Addiction Treatment History**
Type of Service	Record the type of service received; be as specific as possible. ***Child Outpatient Example:*** Inpatient, PHP, Outpatient Group.
Dates of Service	Record the approximate date range of service.
Reason	Record the reason that person received treatment. ***Child Outpatient Example:*** Anxiety
Name of Provider / Agency	Record the name of the provider and/or agency.
Inpatient/Outpatient	Record the type of treatment.
Completed?	Check if person completed the originally planned service. ***Child Outpatient Example:*** Check *No* if person discharged himself against doctor's orders.
Efficacy of past and current treatment	Indicate if treatment was helpful and explain why the person thinks it was or was not helpful.
Psychiatric History (include past diagnosis and course of illness)	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.
Source(s) of Information:	Indicate the where information on the person's mental health service history came from by checking the appropriate box(es).
Data Field	**Medical and Physical Health Summary**
Allergies	List all known food, medication (include OTC and herbal) 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.
Medical and Physical Health Summary	
Current	Record current status of medical/physical functioning (if CANS assessment not completed). Include current physical complaints that may interfere with the person's served functioning, issues of language, speech, hearing, vision, intellectual, sensory, and motor development.
History	Complete significant history regarding physical health, as reported by the child/family members or refer to attached Physical Health Assessment. Record health history including immunization status, prenatal exposure to alcohol and drugs, chronic conditions, significant dental history. **Example:** Joel was born 2 weeks post due date, but was born as the result of a normal birth. Developmental milestones were delayed.
Does the person use complimentary health approaches (e.g. natural products, mind-body practices, yoga)?	Indicate if the person utilizes any complimentary health approaches. If yes, describe.
Does the person wish to consider using complimentary health approaches and want help finding a provider	Indicate if the person would like to consider using complimentary health approaches and/or if they would like help finding a provider. If yes, describe.
Nutritional Screening	Check all that are reported. Include beliefs, perceptions, attitude, behaviors regarding food:
Sexuality	Include concerns with sexual development, sexual behavior, and concerns with sexual identity.
Current	Record current status of the Child/Youth's sexuality.
History/Concerns	Record significant history of Child/Youth sexuality.
Medication information and history of adverse reactions	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 list all other information the person remembers. This is especially important for current medications that the person is taking. Include what medications work well and have worked well previously, any adverse side effects, why person doesn't take medication as prescribed and/or which one(s) the person would like to avoid taking in the future. **If the person served is currently taking any medication, complete and attach the Medication Addendum.**
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	**Mental Status Exam**
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)	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 sad and anxious today.
Emotional State-Affect	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.
___ 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 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.
___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 experienced by individuals who have ingested an illicit drug or drug overdose, someone who is floridly psychotic, 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. Cultural considerations must be taken into account and to distinguish if the "hallucination" is culture bound as opposed to an authentic hallucination.
___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 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."
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 from his/her childhood or in the past?
__**Short Attention Span**	Can the person tell what event happened 5 minutes ago?
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: 1. 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? If you found a fully addressed and stamped envelope on the sidewalk, what would you do?
___ **Mild**	**2** 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. Take necessary steps to notify supervisors and appropriate authorities if the situation warrants.
****	**Checking any item with ** requires an immediate risk and/or lethality assessment.**
Data Field	**Person's Served Strengths/Abilities/Resiliency**
Personal Qualities- Adaptable, Persistent, Curious, Playful, Creative, Confident, Optimistic, Resilient	Describe the personal qualities (strengths/capabilities), as identified by the client or family, and the clinician that can be put into service toward achievement of the person's goals. ***Child Outpatient Example:*** Joel is a curious boy who likes to explore how things are made.
Living Situation, Family, and Interpersonal Relationships	Describe the person's strengths and capabilities regarding his/her daily living situation. Record the community resources available to the person. ***Child Outpatient Example:*** Joel lives in a loving family and has a close relationship with both parents, his grandmother and aunt. .
Financial/Employment/ Education	Describe the person's strengths and capabilities regarding his/her employment/education situation. ***Child Outpatient Example:*** Joel puts in a lot of effort in trying to accomplishing his schoolwork and homework
Health	Describe the person's strengths and capabilities regarding his/her health. ***Child Outpatient Example:*** Joel is in excellent health and his parents take him to the doctor for his annual checkups as well as to sick visits when he is ill.
Leisure/ Recreational/ Community Involvement and Connections/Talents and Interests	Describe the person's strengths and capabilities regarding his/her leisure/recreational skills. ***Child Outpatient Example:*** Joel loves to play on the swings.
Spirituality/Culture/ Religion	Describe the person's strengths and capabilities regarding his/her spirituality, culture and/or religion. ***Child Outpatient Example:*** Joel and his family attend church weekly and are connected to their church community.
Data Field	**Assessed and Needs Checklist Including Functional Domains**
Check Current Need Areas (CN) and Check areas where Person/Family Desires	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

Change Now (PD)	Daily Living, Addictive Behaviors, Behavior Management, Family and Social Support, Mental Health/ Illness Management, Physical Health, Risk/Safety and Other.
Current Needs Selected Above 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.

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. 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. List the symptoms that support your diagnosis. 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-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.
Check Primary/ Billing Diagnosis	Check the primary/billing diagnosis.
Code	Indicate the ICD-10 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	**Treatment Recommendations/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. ***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 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.
Person's Service Preferences, 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. ***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. *****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	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/	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

Credential (If needed)	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.

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 <u>strongly supported by the symptoms, behaviors and skills deficits and abilities/needs documented in the earlier sections of the assessment or this update</u>. 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.**

Risk Assessment

The following assessment tool is to be used if the person served has made contact with a behavioral health professional and is willing to work with us, to some degree to assess risk. If a person is fully determined to take their own life or that of another, there may be nothing a behavioral health professional can do to prevent this from occurring. The assessment of risk is complicated and is based on many interacting factors. The items in this tool are based on research and many years of practical experience. The tool is a means to gather data. This data must then be considered in its entirety before making a determination of risk.

Data Field	Person Demographic Information
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.
Data Field	**Safety and Protective Factors**
Safety and Protective Factors	These factors often support individuals with self-management of risk issues. Many of these factors are found elsewhere in the assessment but repeated here for ease of formulating concerns about risk. Indicate below by checking yes, no, or not known if the person is currently engaged with any Safety and Protective Activities. **Comment on each yes answer.**
Stable Housing	
Stable Employment	
Has Income/Insurance/ Benefits	
Has Positive Alliance with Service Providers	
Experience Positive Benefits from Treatment	
Seeks Assistance When at Risk/in Danger	
Had Developed a Crisis/Safety Plan/ WRAP Plan/ Self Care Plan	
Medication Adherence	
Able to Plan and Follow Through	
Capacity for Empathy/Perspective Taking	
Religious/ Spiritual Beliefs or Involvement	
Stable/Positive Personal Relationships	

Positive Family Supports/ Has Children or Pets	
Has Insight About Her/ His Symptoms	
Sobriety/ No Active Substance Use	
Low Psychosocial Stressors	
Capacity to Weigh Risks and Benefits of Decisions	
Capacity for Emotional Self-Regulation	
Capacity for Self-Management of Behaviors	
Future Orientation/ Goals	
Recovery Orientation	
Data Field	**Risk Factors**
Harm to Others Factors	Indicate below if the person has any past or current risk factors relating to the category. For each item marked "past" or "current", please not the context of the risk factor and any other relevant information regarding its occurrence. If there is current presentation of an acute risk, such as suicidal ideation, homicidal ideation, etc., please refer to agency specific protocols.
Thoughts/ Plans for Harming/ Killing Others	
Direct Violent Thoughts	
Indirect Threats Implying Violence	
Verbal Aggression that Precedes Violence	
Serious Property Damage	
Physical Assault/ Violence to Others	
Sexual Assault Against Others	
Illegal or Antisocial Behaviors/ Arrest/ Conviction/ NGRI/ Incarceration	
Neglect or Abuse of Dependents	
Stalking/ Restraining Order/ Obsession Targeted at a Particular Person	

Arson/ Fire Setting/ Fire Safety Issues	
Extreme Paranoia/ Perception of Threats/ Command Hallucinations to Harm Others	
Failure of Prior External Supervision to Control or Reduce Harm to Others	
Other Harm or Danger to Others Issues	
Other Harm or Danger to Others Issues	
Data Field	**Self-Harm Factors**
Suicidal Thoughts/ Plans/ Rehearsal Behaviors	
Suicide attempts	
Self-Harm Behaviors	
Family History of Suicidal/ Self-Harm	
Life Threatening Eating Disorder	
Victimized by Others/ Places Self in Danger	
Command Hallucinations for Self-Harm	
Elopement Without Ability to Self-Preserve	
Other Self Harm	
Other Self Harm	
Other Self Harm	
Data Field	**Other Risk Factors**
	These factors may increase the level of concern a clinician has regarding potential risk.
Recent Significant Loss	
Memory Impairment/ Dementia/ Disorientation	
Developmental Disability/ PDD Spectrum	
Young Age at Time of First Violent Behavior	
Early Attachment Issues	
Traumatic Brain Injury	

Cognitive Impairment/ Learning Disability	
Extreme Impulsivity	
Presents with Trauma Related Symptoms	
Lack of Empathy/ Remorse When Aggressive	
Injury to Animals	
Positive View of Criminal Behavior	
Requires Substitute Decision Making	
Access to/ Keeping/ Carrying/ Using Weapons	
Non-Violent Problematic Sexual Behavior	
Person is Actively Abusing Substances	
Increased Risk Associated with Presence of Psychiatric Symptoms	
Unwilling/ Unable to Engage in Shared Risk Decisions/ Risk Reduction Efforts	
Chronic Medical Illness or Chronic Pain	
Unable/ Unwilling to Manage Risks	
Experiencing Acute High Stress Situation	
Data Field	**Summarize the Risk and Protective Factors**
Summarize the Risk and Protective Factors and Indicate if Further Planning is Needed per Agency Protocols	
Data Field	**Signatures**
Person's Signature (Optional, if clinically appropriate)	Signature of the person to be served by the agency indicating his/her understanding and acceptance of the treatment recommendation/assessed needs.
Date	Record the date of the signature.

Parent/ Guardian Signature (if appropriate)	
Date	Record the date of the signature.
Clinician/ Provider- Print Name/ Credential	**Legibly print** name and credential(s) of person completing the Comprehensive Assessment.
Date	Record the date of the signature.
Supervisor- Print Name/ Credential (if needed)	If the diagnosis is rendered by a clinician other than the clinician printed above, then the clinician rendering the diagnosis must print his/her educational level and highest license level.
Date	Record the date of the signature.
Clinician/ Provider Signature	**Legible signature** of person completing the Comprehensive Assessment.
Date	Record the date of the signature.
Supervisor Signature (if needed)	If the diagnosis is rendered by a clinician other than the clinician signed above, then the clinician rendering the diagnosis must provide his/her signature and record his/her educational level and highest license level.
Date	Record the date of the signature.
Psychiatrist/MD/DO (if required)	This is a requirement for Opiate Treatment Programs.

Initial Psychiatric Evaluation

This form is to be completed by a psychiatrist, CNS or other APN with credential in psychiatry and prescribing privileges, to document an initial psychiatric evaluation.

Data Field	Person Demographic Information
Person's Name	Record the first name, last name, and middle initial of the person. 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 (usually first service date for this service episode).
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.
Data Field	**Present at Session**
List Name(s) of Person(s) Present	Check appropriate box: *Person Present; Person No Show; Person Canceled.* If *Provider Canceled* is checked, document explanation as relevant. If *Others Present* is checked, identify name(s) and relationship(s) to person.
Data Field	**Place of Evaluation**
Place of Evaluation	Check the appropriate box to indicate where the evaluation took place. If other, specify.
Data Field	**Presenting Concern**
Presenting Concerns in person's own words; what occurred to cause the person to seek services now	Use the person's own words to document the reason the person is asking for help. This should be a concise but complete description of why the person is seeking help now; including troublesome symptoms, behaviors and problems in functioning in life roles.
Data Field	**Comprehensive Assessment**
History of Present Illness	Document/summarize any history with the present illness. This can include onset of symptoms and what was done to manage illness prior to seeking help. Check *None Reported* if applicable.
Comprehensive Assessment has been completed?	Check Yes or No and indicate date of most recent assessment.
Data Field	**Primary Care Provider Information**
Primary Care Provider (PCP) Name and Credentials/ Address/ Telephone Number/Fax/Date of Last Exam	Record the person's PCP contact information. This may be a RNP or Pediatrician but must be the medical professional primarily in charge of the person's overall physical health care.
Data Field	**Physical Health History**
Physical Heath History	Review the Physical Health section of the Comprehensive Assessment with the person and record the date of the Comprehensive Assessment reviewed. If there is no additional pertinent physical health history, check *No Additional History to be Added*. If there is additional pertinent physical health history, **OR** if the Comprehensive Assessment was not reviewed, check *Additional History/ Comments* and provide the information.

Data Field	Family Mental Health / Substance Use History
Family Mental Health / Substance Use History	Check all that apply or *none reported* and comment as necessary.
Data Field	**Substance Use/Addictive Behavior History**
Substance Use /Addictive Behavior History	Review the Substance Use/Addictive Behavior section of the Comprehensive Assessment with the person and record the date of the Comprehensive Assessment reviewed. If there is no additional pertinent substance use/addictive behavior history, check *No Additional History to be Added*. If there is additional pertinent substance use history, **OR** if Comprehensive Assessment was not reviewed: check *Additional History Indicated Below* and provide the information on this form in the grid below. For reporting substance use, include age of first use, date of last use, frequency, amount and method of use.
Toxicology Screen Completed	Record *Yes* or *No*. If yes, indicate results.
Data Field	**Treatment History**
Type of Service/ Mental Health or Substance Use Name of Provider/Agency/ Dates of Service/Completed (Y/N)	Review the Treatment History section in the Comprehensive Assessment (mental health (MH) and substance use (SU) with the person and record the date of Comprehensive Assessment reviewed. If there is no additional pertinent treatment history, check *No Additional History to be Added*. If there is additional treatment information, **OR** if the Comprehensive Assessment has not been reviewed, check Additional *History Indicated Below* and provide the information on this form in the grid below. record the treatment episodes on this form in the grid below
Data Field	**Assessment Domains**
Additional Pertinent Information	Review each area if the Assessment Domains listed in the Comprehensive Assessment and record the date of Comprehensive Assessment reviewed. For each area, if there is no additional pertinent treatment history, check *No*. If there is additional treatment information, **OR** if the Comprehensive Assessment has not been reviewed, check Yes and provide the information in *Comments*.
Data Field	**Mental Status Exam**
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: 1. 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? **2.** 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.**
Data Field	**Summary of Current Mental Health Functioning**
Other symptoms of note or information from other sources (family, referring agency, etc.)	Record any other pertinent information/ symptoms of note, including that from other sources (family, referring agency, etc.).
Data Field	**Diagnoses/Justification and Differential Diagnosis**
General Instructions:	Each agency should have adequate internal processes to ensure the diagnostic impression recorded in the Comprehensive Assessment is reconciled with the diagnoses in the Psychiatric Evaluation. 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.
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	**Medication Information/Side Effects/Adverse Drug Reactions**
Medication Information (Medication, Current or Past, Rationale/Condition, Dosage/Route/Frequency, Person Taking/Took Meds as Prescribed)	If Comprehensive Assessment has not been completed and been reviewed, complete this section. If the CA has been completed and reviewed, provide any relevant updates. **Comments on Past Medications:** Include what medications have worked well previously, any adverse side effects, and/or which one(s) the person would like to avoid taking in the future. If there have been no medication changes (including dosage changes, added or discontinued medications, etc.), check *There Have Been No Medication Changes*. If there are changes, **OR** if the Comprehensive Assessment has not been reviewed, check *Additional Medication Changes Below* and provide the information on this form in the grid below. Include medication name, current (C) or past (P), rationale/condition for which the medication is/was taken, dosage/route/frequency and if meds were taken as prescribed. Be sure to include all types of medications: prescribed, herbal, and over-the-counter. **Example:** If the person has discontinued a medication since the assessment, this should be so indicated by listing medication and checking (P) in the Current/Past column. This would also apply if the person began and discontinued a medication since the assessment reviewed.

Reported side effects/adverse drug reactions/other comments on current or past medications	Record and comment on any side effects reported by person /guardian to past or present medications or check "none reported." This section should be completed for all persons, regardless of whether the information has already been completed in the Comprehensive Assessment.
Does the person served have any medical conditions that require consideration in prescribing (i.e. pregnancy, diabetes, etc.)?	Check yes or none reported or known. If yes, please specify.
Data Field	**Medications Prescribed/Informed Consent/Lab Tests**
Medication/Status/Rational and Condition/Dosage, Route, and Frequency/Amount and Refills	If there are to be no medication changes (including dosage changes, added or discontinued medications or refills), check *None.* If there are changes of any type, check either *new/adjusted* (for new medications ordered or medications being prescribed at a different frequency or dose); *refill* (for those medications simply being ordered again without change); or *discontinued* (for medications being discontinued). Include rationale/condition, dosage/route/frequency and the amount/refills being ordered. Also be sure to include all types of medications: prescribed, herbal, over-the-counter.
Explained rationale for medication choices, reviewed mixture of medications, discussed possible risks, benefits, effectiveness (if applicable) and alternative treatment with the person (parent/guardian)	Check *Yes* or *No* to indicate whether the rationale, risks and benefits of the particular mixture of medications prescribed and any alternative treatments or medications and effectiveness (if applicable) have been explained to the person during this evaluation.
Person	Check the appropriate box.
Guardian	Check the appropriate box.
Laboratory Tests Ordered	List all laboratory tests ordered in this session or check *None Ordered* if no laboratory tests were ordered.

Data Field	**Follow Up Plan and Other Considerations**
Follow Up Plan/Referrals	This section should describe the immediate follow-up plan to this visit. Include as appropriate referrals, labs or other additional testing ordered, medical strategies, other types of treatment and frequency/interval of next visit. Record issues that need to be addressed in future appointments.
Other Psychopharmalogical Considerations to be Added to the Individualized Action Plan	If clinically indicated, record suggestions for consideration of other services to be added and included in the IAP and/or IAP Revision. Check *None indicated at this time* if no other services are to be added.
Person's/ Guardian Response to Plan	Note the Person's/Guardian's response to the follow up plan, or check N/A if not applicable.
Data Field	**Staff Signatures**
Physician/APRN/RNCS Print Name/Credentials	Legibly print name of the prescriber including his/her credentials. Example: Luisa Cabot, MD
Date	Record the date.

Supervisor – Print Name/ Credentials (if needed)	If required, legibly record supervisor's name and credentials**.**
Date	Record the date.
Physician/APRN/RNCS Signature	Legibly record signature of the prescriber including his/her credentials. **Example:** Luisa Cabot, MD
Date	Record the date.
Supervisor Signature (if needed)	If required, legibly record supervisor's signature and credentials.
Date	Record the date.
Person's Signature (Optional, if appropriate)	The person is given the option to sign. If completing the note after the session and/or if using electronic notes, person can sign at next session.
Date	Record the date.

Tobacco Assessment

Data Field	Person Served Demographic Information Instruction
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	
Organization/Program Name	Record the organization/program for whom you are delivering the service.
DOB	Record person's date of birth.
Gender	Record the appropriate gender. If checking "Transgender" box, also complete box of current gender designation for insurance purposes.
Data Field	**ASK**
Systematically identify all tobacco users at every visit	If the person never used tobacco or is a recovering tobacco user, check applicable box and follow prompts on the form. Form is complete for these people. If the person is a current smoker, record amount, type of use and time elapsed upon waking until tobacco use in corresponding sections and check all boxes that apply.
Data Field	**ADVISE**
Strongly urge all tobacco users to quit	Follow prompt provided (or similar) in encouraging tobacco user to consider quitting and check box.
Data Field	**ASSESS**
Determine willingness and readiness to make an attempt to quit	Follow prompt questions and check the corresponding box on left as asked and completed. Show person served the 1-10 scale examples on the form as a guide in his/her selection. For people who answer 1-4 for the question "How interested are you in quitting?" complete the question, "What would make you more interested?" For people who answer 1-4, ask "How confident are you that you could successfully quit? And ask "How could the program help you become more confident." For all person's served complete the question, If you were to quit, what would be some reasons?
Stage of Change	Based upon responses to the previous questions assess and check the person's stage of change related to quitting tobacco use.
If in Preparation, ask	For persons assessed as in the "Preparation" stage, document steps the person has taken toward his/her preparation to quit.
Data Field	**ASSIST**
Evaluate past quitting experience	Indicate how many attempts the person has made to quit in the past and check box to the left.
Discuss available programs	Review what your program can offer in the way of information and support and check box to the left. Give the person desired materials as available and once again encourage the person to consider quitting and/or to follow-up with information provided.
Data Field	**ARRANGE**
Schedule Follow-up Contact	Check all boxes that apply indicating whether a referral was offered, will occur as part of regular Individualized planning, and whether the person would like referral or not.
Data Field	**Signatures**
Person's Signature (Optional, if clinically appropriate)	Signature of the person to be served by the agency indicating his/her understanding and acceptance of the treatment recommendation/assessed needs.
Date	Record the date of the signature.
Parent/ Guardian Signature (if appropriate)	

Date	Record the date of the signature.
Clinician/ Provider- Print Name/ Credential	Legibly print name and credential(s) of person completing the Comprehensive Assessment.
Date	Record the date of the signature.
Supervisor- Print Name/ Credential (if needed)	If the diagnosis is rendered by a clinician other than the clinician printed above, then the clinician rendering the diagnosis must print his/her educational level and highest license level.
Date	Record the date of the signature.
Clinician/ Provider Signature	**Legible signature** of person completing the Tobacco Assessment.
Date	Record the date of the signature.
Psychiatrist/MD/DO (if required)	
Date	Record the date of the signature.

Infectious Disease Risk Assessment

The Infectious Disease Risk Assessment Form is to be completed following the Comprehensive Assessment by all programs that receive Department of Public Health funding or others who wish to utilize it. This assessment is best conducted in an interview type manner by a clinically trained person who has some familiarity with HIV and other sexually transmitted diseases, HIV testing sites and other resources. At a minimum, agencies should provide staff conducting this assessment with a one page fact sheet on HIV that includes basic facts about HIV and a list of local testing sites. It is recommended that a fact sheet on Hepatitis C also be created as an adjunct to the HIV fact sheet. The DPH website has materials prepared in multiple languages.

Data Field	Person Served Demographic Information
Person's Name	Person should be informed that recording their name is optional on this form. If person agrees, 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.
Organization/Program Name	Record the organization/program for whom you are delivering the service.
DOB	Record the person's date of birth.
Gender	Record the person's gender. If checking "Transgender" box, also complete box of current gender designation for insurance purposes.
Data Field	**Drug Use / Route**
1. What drugs do you usually use? 2. **How do you use your drugs?**	Check all drugs which the person reports use. Check all applicable routes of use for the drugs checked in question 1.
Data Field	**Needle Use (for non-IV drug users check N/A for questions 3-6**
3. If you inject drugs, how often do you use new needles?	If person injects drugs, ask how often new needles are used and check the box indicated. If response is anything other than always, inform person that even if cleaning needles (his/her own or someone else's), there is still a risk of getting infections. Review where new needles may be obtained (i.e. pharmacy, needle exchange programs).
4. If you use new needles, where do you get them?	Check all applicable sources of new needles for the person and review underutilized resources as applicable.
5. If you use needles, how do you dispose of them?	Check all applicable disposal methods and review with person the importance of safe disposal in order to reduce the risk of harm or infection to self and others. Review best practices of needle disposal and options available to the person as applicable.
6. Do you ever share needles/injection equipment?	Check yes, no or not applicable. Inform the person that risk of infection is possible not only through shared needle use, but also through sharing of other injection equipment (i.e. water, spoons, etc.).
Data Field	**Sexual Activity**
7. In the last five years, about how many people have you had sex with?	Check the box that reflects the approximate number of sexual partners / encounters in the past five years. Sexual contact includes both intercourse and oral sex for the purpose of this question.
8. How often do you use protection against infections?	If the person reports long term abstinence, check N/A. Otherwise, check frequency of use of protection and review risks involved with unprotected sex and forms of protection as applicable.
9. Have you had sex for money, drugs or something	Check yes or no based on the person's response. If yes, discuss alternatives to getting needs met as appropriate.

you needed?	
Data Field	**HIV Testing / Resources / Recommendations**
10. When was the last time you were tested for HIV?	Indicate date of last HIV test or never.
11. Did you receive your results?	Indicate N/A or whether the person received results from their last HIV test. If the person did not receive results, have conversation about what prevented this and offer assistance as applicable.
12. Would you like more information about HIV where to get tested / treated?	Ask the person if they have questions about HIV, other Sexually Transmitted Diseases or testing. Check the corresponding box. Provide the person with desired information or referrals.
Please check what was provided to Person Served below:	Check and record information provided to the person or check "discussion only" if no other information was given.
Other Notes / Recommendations	Record any other pertinent information or specifics related to recommendations given to the person in this section.
Data Field	**Signatures**
Person's Signature (Optional, if clinically appropriate)	Signature of the person 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.
Parent/Guardian Signature (if appropriate)	
Date	Next to each signature record the date of the signature.
Clinician/Provider – Print Name/Credential	**Legibly print** name and credential(s) of person 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 printed 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.
Clinician/Provider Signature	**Legible signature** of person completing the Comprehensive 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 signed above, then the clinician rendering the diagnosis must provide his/her signature and record his/her educational level and highest license level.
Date	Next to each signature record the date of the signature.
Psychiatrist/MD/DO (if required)	This is a requirement for Opiate Treatment Programs.

Physical Health Assessment

- ✓ Required for JCAHO certified programs and some DPH services; completed in concert with the comprehensive assessments.
- ✓ Optional for other programs following agency policies.
- ✓ Assess current and past medical issues of the person served that may impact current functioning.
- ✓ To be completed by qualified Medical Professional.

Data Field	Identifying Information Instruction
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.
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.
Data Field	**Vital Signs**
	Record height, weight, blood pressure, body mass index, respiratory rate, pulse and temperature for person.
Data Field	**Allergies**
	List all known food, medication (include OTC and herbal) 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.
Data Field	**Recent Assessments /Examinations**
Most Recent Blood work	Complete section for all applicable assessments and /or examinations. Additional blood work is required for Opiate Treatment Programs (OTP)
Date	Record date of test performed
Results	Record results of test performed
Physician	List name of physician providing test results
Most Recent Screening	Complete section for all applicable screenings. Additional screenings are required for Opiate Treatment Programs (OTP)
Date	Record date of test performed
Results	Record results of test performed
Physician	List name of physician providing test results
Data Field	**Medical Hospitalizations**
Medical Hospitalizations	If the person was not hospitalized recently for medical reasons, check None Reported
Hospital	If the person was hospitalized recently, indicate the hospital name and location for each hospital stay
Date(s) of Service	Record the date(s) of each hospitalization
Reason (Medical Procedure, Acute Illness, Birth of Child, Etc)	Record the reason for each hospitalization.

Data Field	**Unresolved Surgical Care Needs**
Unresolved Surgical Care Needs	Explain care needs relative to recently performed surgical procedures.
Data Field	**Complimentary Health Approaches**
Does the person use complimentary health approaches (e.g. natural products, mind-body practices, yoga)?	Indicate if the person utilizes any complimentary health approaches. If yes, describe.
Does the person wish to consider using complimentary health approaches and want help finding a provider	Indicate if the person would like to consider using complimentary health approaches and/or if they would like help finding a provider. If yes, describe.
Data Field	**Respiratory System**
	Check all boxes that apply and complete requested details that represent person's medical status. If none reported, check no and skip to next section.
Data Field	**Endocrine System**
	Check all boxes that apply and complete requested details that represent person's medical status. If none reported, check no and skip to next section.
Diabetes	Check all boxes that apply and complete requested details that represent person's medical status. If none reported, check no and skip to next section.
Data Field	**Neurologic Disorder**
	Check all boxes that apply and complete requested details that represent person's medical status. If none reported, check no and skip to next section.
Data Field	**Movement Disorder**
Movement Disorder	Check all boxes that apply and complete requested details that represent person's medical status. If none reported, check no and skip to next section.
Data Field	**Immune System Disorders**
	Check all boxes that apply and complete requested details that represent person's medical status. If none reported, check no and skip to next section. If AIDS/HIV status is recorded DPH/DMH regulation requires that the form is kept separate from the regular medical record and secured unless a written authorization was obtained from the person served.
Data Field	**Bacterial/Viral Infections**
	Check all boxes that apply and complete requested details that represent person's medical status. If none reported, check no and skip to next section.
Data Field	**Visual Impairment**
	Check all boxes that apply and complete requested details that represent person's medical status. If none reported, check no and skip to next section.
Data Field	**Auditory Impairment**
	Check all boxes that apply and complete requested details that represent person's medical status. If none reported, check no and skip to next section.
Data Field	**Digestive/Urinary Conditions**

	Check all boxes that apply and complete requested details that represent person's medical status. If none reported, check no and skip to next section.
Data Field	**Dental Conditions**
	Check all boxes that apply and complete requested details that represent person's medical status. If none reported, check no and skip to next section.
Data Field	**Reproductive Health**
	Check all boxes that apply and complete requested details that represent person's medical status. If none reported, check no and skip to next section.
Data Field	**Advanced Directives in place**
	Check all boxes that apply.
Data Field	**Pain Assessment Screening**
	Indicate the person's reported level of pain today using zero to 10 point scale
Does pain currently interfere with your daily activities?	Check Yes or No. If yes, indicate the degree to which pain interferes with person's activities.
Data Field	**Ambulation**
	Check all boxes and complete requested details that represent person's medical status.
Data Field	**Dietary**
	Check all boxes and complete requested details that represent person's medical status.
Data Field	**Diseases of the Liver**
	Check all boxes and complete requested details that represent person's medical status.
Data Field	**Dermatologic Conditions**
	Check all boxes and complete requested details that represent person's medical status.
Data Field	**Cancer**
Cancer	Check Yes or No. If yes, indicate type of cancer and treatments received.
Currently in remission	Check Yes or No. If yes, indicate how long the person has been in remission (years/months).
Data Field	**Bone and Joint Conditions**
	Check all boxes that apply and complete requested details. If none reported, check no and skip to next section.
Have these conditions led to:	Check all boxes that apply.
Data Field	**Comments**
	Record any comments.
Data Field	**For Opiate Treatment Programs:**
	For Opiate Treatment Programs a specific comprehensive physical examination, completed by a medical professional, must be attached.
Data Field	**Comments, Recommendations or Referrals by Medical Reviewer:**
	If no referral needed, skip to signature and credential section.
Data Field	**Check Referral(s) Needed and Specify Action(s)**

	Check all resources needed for referral. Specify reason for referral to provider.
Data Field	**Recommendation shared with person served**
	Check yes or no. If yes, record person's served response to recommendations. If no, indicate how recommendations will be shared with person served.

Data Field	Signatures
Person's Signature (Optional, if clinically appropriate)	Signature of the person 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.
Parent/Guardian Signature (if appropriate)	
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Psychiatrist/MD/DO (if required)	This is a requirement for Opiate Treatment Programs.