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 y*es* 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	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

Person/Family Desires Change Now (PD)	above with emphasis on those areas that interfere with or prevent assumption or continuation of the person's self-determined valued life roles in the areas of Activities of Daily Living, Addictive Behaviors, Behavior Management, Family and Social Support, Mental Health/ Illness Management, Physical Health, Risk/Safety and Other.
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/ 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.