



<b>Person's Name (First / MI / Last):</b>	<b>Record #:</b>
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**Organization Name:**

**SECTION I: Reason for Update – This section may be completed by an unlicensed provider**

Annual Update   
  Re-Admission   
  Interim Update of New Information

**Date of Most Recent Comprehensive Assessment:**

**Adult Comprehensive Assessment Sections for Update**

Check the box(es) next to the section(s) of the assessment (including addendums), which you are updating. Be sure to label all additional/updated information in your narrative with the heading of the section of the Assessment or Addendum being updated.

<input type="checkbox"/> Presenting Concerns	<input type="checkbox"/> ASAM Dimensions
<input type="checkbox"/> Living Situation	<input type="checkbox"/> Mental Health Service History
<input type="checkbox"/> Family and Social Support History	<input type="checkbox"/> Medication Information
<input type="checkbox"/> Legal Status and Legal Involvement and History	<input type="checkbox"/> Health Summary
<input type="checkbox"/> Education	<input type="checkbox"/> Trauma History
<input type="checkbox"/> Employment	<input type="checkbox"/> Mental Status Exam
<input type="checkbox"/> Military Service	<input type="checkbox"/> Assessed Needs Checklist
<input type="checkbox"/> Substance Use/Addictive Behavior History	<input type="checkbox"/> Strengths/Capabilities/Resiliency
<input type="checkbox"/> Substance Use/Addictive Behavior Service History	<input type="checkbox"/> Other:

**Update Narrative:** List each assessment section being updated with narrative explanation below it.

<b>Signature/Credentials</b> (If Licensed Clinician did not obtain the information above):	<b>Date:</b>
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**SECTION II: Diagnosis Change – This section must be completed by a qualified provider**

**Diagnosis:**   
 No Change   
 List all current Diagnoses below  
 DSM Codes (or successors)   
 ICD Codes (or successors)

Check Primary	Axis	Code	Narrative Description
	Axis I		
	Axis II		
	Axis III		
	Axis IV		
	Axis V	Current GAF:	Highest GAF in Past Year (if known):

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**Person Served /Family/Guardian Expression of Service Preferences**

**1. Service Preferences:**

<b>Treatment Recommendations / Assessed Needs:</b> <input type="checkbox"/> No Additional Recommendations Clinically Indicated <small>A-Active, PD-Person Declined, D-Deferred, R-Referred Out (If declined/deferred/referred out, please provide rationale)</small>	A	PD*	D*	R*
1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**\*Person Declined/Deferred/Referred 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 below).  None**

- 1.
- 2.
- 3.

**ASAM Degree of Severity at Admission for the following Dimensions**

(SU Persons only -  NA)

Dimension	Intoxication / Withdrawal Potential	Biomedical Conditions/ Complications	Emotional / Behavioral / Cognitive	Readiness to Change	Relapse / Continued Use Potential	Recovery Environment	Family Functioning (Youth Only)
	0 - <input type="checkbox"/> None 1 - <input type="checkbox"/> Low 2 - <input type="checkbox"/> Moderate 3 - <input type="checkbox"/> High 4 - <input type="checkbox"/> Severe	0 - <input type="checkbox"/> None 1 - <input type="checkbox"/> Low 2 - <input type="checkbox"/> Moderate 3 - <input type="checkbox"/> High 4 - <input type="checkbox"/> Severe	0 - <input type="checkbox"/> None 1 - <input type="checkbox"/> Low 2 - <input type="checkbox"/> Moderate 3 - <input type="checkbox"/> High 4 - <input type="checkbox"/> Severe	0 - <input type="checkbox"/> None 1 - <input type="checkbox"/> Low 2 - <input type="checkbox"/> Moderate 3 - <input type="checkbox"/> High 4 - <input type="checkbox"/> Severe	0 - <input type="checkbox"/> None 1 - <input type="checkbox"/> Low 2 - <input type="checkbox"/> Moderate 3 - <input type="checkbox"/> High 4 - <input type="checkbox"/> Severe	0 - <input type="checkbox"/> None 1 - <input type="checkbox"/> Low 2 - <input type="checkbox"/> Moderate 3 - <input type="checkbox"/> High 4 - <input type="checkbox"/> Severe	0 - <input type="checkbox"/> None 1 - <input type="checkbox"/> Low 2 - <input type="checkbox"/> Moderate 3 - <input type="checkbox"/> High 4 - <input type="checkbox"/> Severe

**Further Evaluations Needed:**

- None Indicated   
  Psychiatric   
  Psychological   
  Neurological   
  Medical   
  Educational   
  Vocational  
 Visual   
  Auditory   
  Nutritional   
  SU Assessment   
  Other:

**Was Outcomes tool administered?**  Yes  No If Yes, specify:

**Level of Care/ Indicated Service Recommendation:**  No change

**Person Served/Guardian/Family Response To Recommendations:**  Not applicable

