AC-OK: ADULT Screen for Co-Occurring Disorders (Mental Health, Trauma Related Mental Health Issues & Substance Abuse)

First Name:Last Name:		Last Name:		
Ge	nder:	Date of Birth:	Date of Screening:	
	•	erienced serious depression	n (felt sadness, hopelessness, loss of interest culty going about your daily activities)?	, Yes No
2.	Have you exp	erienced thoughts of harmi	ing yourself?	☐ Yes ☐ No
3.		erienced a period of time veceping up with your thoug	when your thinking speeds up and you this?	Yes No
4.	Have you atte	mpted suicide?		Yes No
5.	Have you had or friends?	periods of time where you	ı felt that you could not trust family	☐ Yes ☐ No
6.	Have you been	n prescribed medication for	r any psychological or emotional problem?	☐ Yes ☐ No
7.	Have you exp Mental H		eard or seen things others do not hear or see) Total yes answers:	? Yes No
8.	Have you ever threatened by		, emotionally or sexually hurt, or	Yes No
9.	•	which interferes with you	and since had repeated nightmares/dreams leading a normal life? Total yes answers:	☐ Yes ☐ No
10.	Have you bee	n preoccupied with drinkin	ng alcohol and/or using other drugs?	☐ Yes ☐ No
11.	Have you exp drugs, and you	_	by drinking alcohol and/or using other	Yes No
12.	Do you, at tim	nes, drink alcohol and/or us	se other drugs more than you intended?	Yes No
13.		ded to drink more alcohol about used to get with less?	and/or use more drugs to get the	☐ Yes ☐ No
14.	Do you, at tim	nes, drink alcohol and/or us	se other drugs to alter the way you feel?	Yes No
15.	Have you trie Substance		and/or using other drugs, but couldn't? 15 Total yes answers:	Yes No
Pro	ovider Represo	entative Signature:		