

AC-OK Screen for Co-Occurring Disorders - Adults

(Mental Health, Trauma Related Mental Health Issues & Substance Abuse)

Client Name:		Client#
DOB:	Date of Service:	
In the past year:		
1. Have you experienced serious depression (felt sadness, hopelessness, loss of interest, change of appetite or sleep pattern, difficulty going about your daily activities)?		<input type="checkbox"/> yes <input type="checkbox"/> no
2. Have you experienced thoughts of harming yourself?		<input type="checkbox"/> yes <input type="checkbox"/> no
3. Have you experienced a period of time when your thinking speeds up and you have trouble keeping up with your thoughts?		<input type="checkbox"/> yes <input type="checkbox"/> no
4. Have you attempted suicide?		<input type="checkbox"/> yes <input type="checkbox"/> no
5. Have you had periods of time where you felt that you could not trust family/friends?		<input type="checkbox"/> yes <input type="checkbox"/> no
6. Have you been prescribed medication for any psychological or emotional problem?		<input type="checkbox"/> yes <input type="checkbox"/> no
7. Have you experienced hallucinations (heard or seen things others do not hear/see)?		<input type="checkbox"/> yes <input type="checkbox"/> no
		Number of 'yes' 1-7:
8. Have you been preoccupied with drinking alcohol and/or using other drugs?		<input type="checkbox"/> yes <input type="checkbox"/> no
9. Have you experienced problems caused by drinking alcohol and/or using other drugs, and you kept using?		<input type="checkbox"/> yes <input type="checkbox"/> no
10. Do you, at times, drink alcohol and/or use other drugs more than you intended?		<input type="checkbox"/> yes <input type="checkbox"/> no
11. Have you needed to drink more alcohol and/or use more drugs to get the same effect you used to get with less?		<input type="checkbox"/> yes <input type="checkbox"/> no
12. Do you, at any time, drink alcohol and/or use other drugs to alter the way you feel?		<input type="checkbox"/> yes <input type="checkbox"/> no
13. Have you tried to stop drinking alcohol and/or using other drugs but couldn't?		<input type="checkbox"/> yes <input type="checkbox"/> no
		Number of 'yes' 8-13:
14. Have you ever been hit, slapped, kicked, emotionally or sexually hurt or threatened by someone?		<input type="checkbox"/> yes <input type="checkbox"/> no
15. Have you experienced a traumatic event and have since had repeated nightmares, dreams, and/or anxiety which interferes with you leading a normal life?		<input type="checkbox"/> yes <input type="checkbox"/> no
		Number of 'yes' 14-15:
Client Signature:		
Provider Signature:		
Provider Printed Name & Credentials:		

Must be completed at intake and renewed yearly.