

AC-OK Screen for Co-Occurring Disorders – Adolescent (10-21)
 (Mental Health, Trauma Related Mental Health Issues & Substance Abuse)

Client Name (print):		Client#
DOB:	Date of Service:	
During the past year, have you:		
1. Felt really sad, lonely, hopeless, stopped enjoying things, wanted to eat more or less, had problems sleeping, or doing what you need to at home or at school?	<input type="checkbox"/> yes <input type="checkbox"/> no	
2. Heard voices or seen things that others don't hear or see?	<input type="checkbox"/> yes <input type="checkbox"/> no	
3. Burned or cut yourself?	<input type="checkbox"/> yes <input type="checkbox"/> no	
4. Been prescribed medication for your feelings?	<input type="checkbox"/> yes <input type="checkbox"/> no	
5. Tried to kill yourself?	<input type="checkbox"/> yes <input type="checkbox"/> no	
6. Had thoughts about hurting yourself or wanting to die?	<input type="checkbox"/> yes <input type="checkbox"/> no	
	Number of 'yes' 1-6:	
7. Been in trouble with the law, school, parents, or lost friends because of your drinking alcohol or using other drugs, and continued to use?	<input type="checkbox"/> yes <input type="checkbox"/> no	
8. Drunk alcohol or used other drugs to change the way you feel?	<input type="checkbox"/> yes <input type="checkbox"/> no	
9. Drunk alcohol or used other drugs more than you meant to?	<input type="checkbox"/> yes <input type="checkbox"/> no	
10. Changed your friends or planned your free time to include drinking alcohol or using other drugs?	<input type="checkbox"/> yes <input type="checkbox"/> no	
11. Needed to drink more alcohol or use more drugs to get the same buzz or high as when you first started using?	<input type="checkbox"/> yes <input type="checkbox"/> no	
12. Tried to stop drinking alcohol or using other drugs, but couldn't?	<input type="checkbox"/> yes <input type="checkbox"/> no	
	Number of 'yes' 7-12:	
13. Have you experienced a very bad thing happen (a traumatic event) where you continue to feel scared, worried, nervous, or even had nightmares that bothered you after it was all over?	<input type="checkbox"/> yes <input type="checkbox"/> no	
14. Have you ever been afraid of your parent, caretaker, or a family member?	<input type="checkbox"/> yes <input type="checkbox"/> no	
15. Have you ever been hit, slapped, kicked, touched in a bad way, cursed at, yelled at or threatened by someone?	<input type="checkbox"/> yes <input type="checkbox"/> no	
	Number of 'yes' 13-15:	
Client Signature:		
Provider Signature:		
Provider Printed Name & Credentials:		

Must be completed at intake and renewed yearly.