Cornerstone Behavioral Healthcare Acehelosu, a division of Cornerstone

AC-OK Screen for Co-Occurring Disorders – Adolescent (10-21)

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?	☐yes ☐no
2. Heard voices or seen things that others don't hear or see?	☐yes ☐no
3. Burned or cut yourself?	☐yes ☐no
4. Been prescribed medication for your feelings?	☐yes ☐no
5. Tried to kill yourself?	☐yes ☐no
6. Had thoughts about hurting yourself or wanting to die?	☐yes ☐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?	☐yes ☐no
8. Drunk alcohol or used other drugs to change the way you feel?	☐yes ☐no
9. Drunk alcohol or used other drugs more than you meant to?	☐yes ☐no
10. Changed your friends or planned your free time to include drinking alcohol or using other drugs?	☐yes ☐no
11. Needed to drink more alcohol or use more drugs to get the same buzz or high as when you first started using?	☐yes ☐no
12. Tried to stop drinking alcohol or using other drugs, but couldn't?	☐yes ☐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?	☐yes ☐no
14. Have you ever been afraid of your parent, caretaker, or a family member?	☐yes ☐no
15. Have you ever been hit, slapped, kicked, touched in a bad way, cursed at, yelled at or threatened by someone?	☐yes ☐no
	Number of 'yes' 13-15:

Client Signature:
Provider Signature:
Provider Printed Name & Credentials:

Must be completed at intake and renewed yearly.