Cornerstone Behavioral Healthcare　　　　Acehelosu, a division of Cornerstone

AC-OK Screen for Co-Occurring Disorders - Adults

Client Name (print):	**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)?	☐yes ☐no
2. Have you experienced thoughts of harming yourself?	☐yes ☐no
3. Have you experienced a period of time when your thinking speeds up and you have trouble keeping up with your thoughts?	☐yes ☐no
4. Have you attempted suicide?	☐yes ☐no
5. Have you had periods of time where you felt that you could not trust family/friends?	☐yes ☐no
6. Have you been prescribed medication for any psychological or emotional problem?	☐yes ☐no
7. Have you experienced hallucinations (heard or seen things others do not hear/see)?	☐yes ☐no
	Number of 'yes' 1-7:
8. Have you been preoccupied with drinking alcohol and/or using other drugs?	☐yes ☐no
9. Have you experienced problems caused by drinking alcohol and/or using other drugs, and you kept using?	☐yes ☐no
10. Do you, at times, drink alcohol and/or use other drugs more than you intended?	☐yes ☐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?	☐yes ☐no
12. Do you, at any time, drink alcohol and/or use other drugs to alter the way you feel?	☐yes ☐no
13. Have you tried to stop drinking alcohol and/or using other drugs but couldn't?	☐yes ☐no
	Number of 'yes' 8-13:
14. Have you ever been hit, slapped, kicked, emotionally or sexually hurt or threatened by someone?	☐yes ☐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?	☐yes ☐no
	Number of 'yes' 14-15:

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

Must be completed at intake and renewed yearly.