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

First Name: ____________________________ Last Name: _________________________________

Gender: _____ Date of Birth: ______________ Last grade completed____ Date of Screening: ______

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

Mental Health Questions 1- 6 Total Yes Answers __________

7. Have you experienced a very bad thing happen (a traumatic event) where you continue to feel scared, worried, or nervous or even had nightmares that bothered you after it was all over? ☐ Yes ☐ No

8. Have you ever been afraid of your parent, caretaker or a family member? ☐ Yes ☐ No

9. Have you ever been hit, slapped, kicked, touched in a bad way, cursed at, yelled at or threatened by someone? ☐ Yes ☐ No

Trauma Questions 7-9 Total Yes Answers________

10. Been in trouble with the law, school, or parents, or lost friends because of your drinking alcohol or using other drugs, and continued to use? ☐ Yes ☐ No

11. Drunk alcohol or used other drugs to change the way you feel? ☐ Yes ☐ No

12. Drunk alcohol or used other drugs more than you meant to ☐ Yes ☐ No

13. Changed your friends or planned your free time to include drinking alcohol or using other drugs? ☐ Yes ☐ No

14. Needed to drink more alcohol or use more drugs to get the same buzz or high as when you first started using? ☐ Yes ☐ No

15. Tried to stop drinking alcohol or using other drugs, but couldn't? ☐ Yes ☐ No

Substance Abuse Questions 10-15 Total Yes Answers___________

Provider Representative Signature: ____