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

First Name: _____Last Name: _____

Gender: _____ Date of Birth: _____ Date of Screening: _____

During 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 or 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 or see)? ☐ Yes ☐ No

Mental Health Questions 1-7 Total yes answers: _____

8. Have you ever been hit, slapped, kicked, emotionally or sexually hurt, or threatened by someone? ☐ Yes ☐ No
9. Have you experienced a traumatic event and since had repeated nightmares/dreams and/or anxiety which interferes with you leading a normal life? ☐ Yes ☐ No

Trauma Questions 8-9 Total yes answers: _____

10. Have you been preoccupied with drinking alcohol and/or using other drugs? ☐ Yes ☐ No
11. Have you experienced problems caused by drinking alcohol and/or using other drugs, and you kept using? ☐ Yes ☐ No
12. Do you, at times, drink alcohol and/or use other drugs more than you intended? ☐ Yes ☐ No
13. 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
14. Do you, at times, drink alcohol and/or use other drugs to alter the way you feel? ☐ Yes ☐ No
15. Have you tried to stop drinking alcohol and/or using other drugs, but couldn't? ☐ Yes ☐ No

Substance Abuse Questions 10-15 Total yes answers: _____

Provider Representative Signature: _____