

**From the practice of Rebecca E Clark, LMFT,
Lifespan Family Healthcare, LLC**

**AC-OK SCREEN FOR CO-OCCURRING DISORDERS - Adults
(Mental Health, Trauma Related Mental Health Issues & Substance Abuse)**

Client Name: (Print) _____ **DOB:** _____ **Date:** _____ **Client #:** _____

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/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

1-7 Total "yes" _____

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 times, 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

8-13 Total "yes" _____

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 since had repeated nightmares/dreams and/or anxiety which interferes with you leading a normal life? Yes No

14 -15 Total "yes" _____

Client Signature: _____ **Provider Signature:** _____