From the office of Lifespan Family Healthcare,
Practice of Rebecca E Clark, LMFT
An Affiliate of Cornerstone Behavioral Healthcare
AC-OK ADOLESCENT SCREEN – Ages 10 thru 21

Client Name (print):_____**DOB::**_____Date:_____Client#_____

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

1-6 Total "yes"_____

7. 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
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

7-12 Total "yes"_____

13. 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
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

13-15 Total "yes"_____

Client Signature: _____ **Provider Signature: _____**
Rebecca E Clark, LMFT

07-11-12 HMJ