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

First Name _____Last Name_____
Gender _____ Date of Birth _____ Date of Screening_____

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 friend? 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 of see)? Yes___ N0___

Questions 1-7 Total YES answers:_____

8. Have you ever been bit, 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 lead a normal life? Yes____ No___

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___

Questions 10-15 Total YES answers _____

Client Signature _____Date_____

Clinician Signature _____ Date_____