Kim Shaffer, LCPC Counseling Services LLC
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Hermon, ME 04401
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AC-OK SCREEN FOR CO-OCCURRING DISORDERS - Adults
(Mental Health, Trauma Related Mental Health Issues & Substance Abuse)

Client Name: _____ **DOB:** _____ **Date:** _____

During the Past Year:

1. Have you experienced serious depression (felt sadness, hopelessness, and 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's Signature: _____ **Provider's Signature:** _____