



Health Affiliates Maine

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 have you:

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: _____