

**AC-OK 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:**

1. Have you been preoccupied with drinking alcohol and/or using other drugs?  Yes  No
2. Have you experienced problems caused by drinking alcohol and/or using other drugs, and you kept using?  Yes  No
3. Do you, at times, drink alcohol and/or used other drugs more than you intended?  Yes  No
4. 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
5. Do you, at times, drink alcohol and/or used other drugs to alter the way you feel?  Yes  No
6. Have you tried to stop drinking alcohol and/or using other drugs, but couldn't?  Yes  No
7. 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
8. Have you experienced thoughts of harming yourself?  Yes  No
9. Have you experienced a period of time when your thinking speeds up and you have trouble keeping up with your thoughts?  Yes  No
10. Have you attempted suicide?  Yes  No
11. Have you had periods of time where you felt that you could not trust family or friends.  Yes  No
12. Have you been prescribed medication for any psychological or emotional problem?  Yes  No
13. Have you experienced hallucinations (heard or seen things others do not hear or see)?  Yes  No
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