NAME: _____

Date: ____/ ____/ _____

Optimae
BEHAVIORAL HEALTH SERVICES

Please mark "Yes" by putting a mark in the column to the right if you experience any of the situations below during the first 18 years of your life.	**Yes**
1. Did a parent or other adult in the household **often . . .** Swear at you, insult you, put you down, or humiliate you? **OR** Act in a way that made you afraid that you might be physically hurt?	☐
2. Did a parent or other adult in the household **often …** Push, grab, slap, or throw something at you? **OR** Ever hit you so hard that you had marks or were injured?	☐
3. Did an adult or person at least 5 years older than you **ever…** Touch or fondle you or have you touch their body in a sexual way? **OR** Try to or actually have oral, anal, or vaginal sex with you?	☐
4. Did you **often** feel that … No one in your family loved you or thought you were important or special? **OR** Your family didn't look out for each other, feel close to each other, or support each other?	☐
5. Did you **often** feel that … You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? **OR** Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?	☐
6. Were your parents ever separated or divorced?	☐
7. Was your mother or stepmother: **Often** pushed, grabbed, slapped, or had something thrown at her? **OR** **Sometimes or often** kicked, bitten, hit with a fist, or hit with something hard? **OR** **Ever** repeatedly hit over at least a few minutes or threatened with a gun or knife?	☐
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?	☐
9. Was a household member depressed or mentally ill or did a household member attempt suicide?	☐
10. Did a household member go to prison?	☐

Now add up your "Yes" answers: _____ This is your ACE Score.

NAME: _____

Date: ____/ ____/ _____

Optimae BEHAVIORAL HEALTH SERVICES

Over the last 2 weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Feeling nervous, anxious, or on edge	0 ☐	1 ☐	2 ☐	3 ☐
2. Not being able to stop or control worrying	0 ☐	1 ☐	2 ☐	3 ☐
3. Worrying too much about different things	0 ☐	1 ☐	2 ☐	3 ☐
4. Trouble relaxing	0 ☐	1 ☐	2 ☐	3 ☐
5. Being so restless that it's hard to sit still	0 ☐	1 ☐	2 ☐	3 ☐
6. Becoming easily annoyed or irritable	0 ☐	1 ☐	2 ☐	3 ☐
7. Feeling afraid as if something awful might happen	0 ☐	1 ☐	2 ☐	3 ☐
Add Columns		+	+	
	Total			

If you checked any of the above problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not at all	Somewhat difficult	Very difficult	Extremely difficult
	0 ☐	1 ☐	2 ☐	3 ☐

NAME: _____

Date: ____/ ____/ _____

Optimae BEHAVIORAL HEALTH SERVICES

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0 ☐	1 ☐	2 ☐	3 ☐
2. Feeling down, depressed, or hopeless	0 ☐	1 ☐	2 ☐	3 ☐
3. Trouble falling or staying asleep or sleeping too much	0 ☐	1 ☐	2 ☐	3 ☐
4. Feeling tired or having little energy	0 ☐	1 ☐	2 ☐	3 ☐
5. Poor appetite or overeating	0 ☐	1 ☐	2 ☐	3 ☐
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0 ☐	1 ☐	2 ☐	3 ☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	0 ☐	1 ☐	2 ☐	3 ☐
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving a lot more than usual	0 ☐	1 ☐	2 ☐	3 ☐
9. Thoughts that you would be better off dead, or thoughts of hurting yourself in some way	0 ☐	1 ☐	2 ☐	3 ☐
Add Columns		+	+	
Total				

If you checked any of the above problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not at all	Somewhat difficult	Very difficult	Extremely difficult
	0 ☐	1 ☐	2 ☐	3 ☐

For Office Use Only	
Dx? **Bipolar** ☐ **MDD** ☐ **Neither** ☐	**Tobacco Use?** **Yes** ☐ **No** ☐
PHQ-9 Score: **<10** ☐ **10+** ☐	**Referred to QuitLine?** **Yes** ☐ **No** ☐

NAME: _____

Date: ____/ ____/ _____

Please indicate "yes" or "no" in response to the following questions. When thinking about drug use, include illegal drug use and the use of prescription drugs other than as prescribed.	**Yes**	**No**
1. Have you ever felt you ought to cut down on your drinking or drug use?	☐	☐
2. Have people annoyed you by criticizing your drinking or drug use?	☐	☐
3. Have you felt bad or guilty about your drinking or drug use?	☐	☐
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	☐	☐
Total Number of "Yes" Responses:		