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ACEs Questionnaire

Adverse Childhood Experiences (ACEs) Questionnaire

Client Full Name:

Client ID Number:

Date of Assessment:

Prior to your 18th birthday:

1. Did a parent or other adult in the household often or very 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?

- [ ] Yes
- [ ] No

2. Did a parent or other adult in the household often or very often…

Push, grab, slap, or throw something at you?
or
Ever hit you so hard that you had marks or were injured?

- [ ] Yes
- [ ] No

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
Attempt or actually have oral or anal intercourse with you?

- [ ] Yes
- [ ] No

4. Did you often or very 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

- [ ] Yes

☐ No

5. Did you often or very 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?

☐ Yes

☐ No

6. Was a biological parent ever lost to you through divorced, abandonment, or other reason?

☐ Yes

☐ No

7. Was your mother or stepmother:
Often or very often pushed, grabbed, slapped, or had something thrown at her?
or
Sometimes, often, or very 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?

☐ Yes

☐ No

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?

☐ Yes

☐ No

9. Was a household member depressed or mentally ill?
or
Did a household member attempt suicide?

☐ Yes

☐ No

10. Did a household member go to prison?

☐ Yes

☐ No

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GAD-7 Scale

Generalized Anxiety Disorder 7-item Scale (GAD-7)

Patient Name:

Date of Visit:

Client Questions

Over the past 2 weeks, how often have you been bothered by any of the following problems?

1. Feeling nervous, anxious, or on edge:

2. Not being able to stop or control worrying:

3. Worrying too much about different things:

4. Trouble relaxing:

5. Being so restless that it's hard to sit still:

6. Becoming easily annoyed or irritable:

7. Feeling afraid as if something awful might happen:

Questionnaire Score

Add up all the numbers for answers 1-7 above.
Total Score:

10. If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?:

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Copy of GAD-7 Scale 1

Generalized Anxiety Disorder 7-item Scale (GAD-7)

Patient Name:

Date of Visit:

Client Questions

Over the past 2 weeks, how often have you been bothered by any of the following problems?

1. Feeling nervous, anxious, or on edge:

2. Not being able to stop or control worrying:

3. Worrying too much about different things:

4. Trouble relaxing:

5. Being so restless that it's hard to sit still:

6. Becoming easily annoyed or irritable:

7. Feeling afraid as if something awful might happen:

Questionnaire Score

Add up all the numbers for answers 1-7 above.
Total Score:

10. If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?:

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DAST-10

Drug Abuse Screening Test (DAST-10)

General Instructions: "Drug use" refers to (1) the use of prescribed or over-the-counter drugs in excess of the directions, and (2) any nonmedical use of drugs. The various classes of drugs may include cannabis (marijuana, hashish), solvents (e.g., paint thinner), tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). The questions do not include alcoholic beverages. Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

Client Full Name:

Client ID Number:

Date of Assessment:

These questions refer to drug use in the past 12 months. Please answer "No" or "Yes"

1. Have you used drugs other than those required for medical reasons?

- [ ] No
- [ ] Yes

2. Do you use more than one drug at a time?

- [ ] No
- [ ] Yes

3. Are you always able to stop using drugs when you want to?

- [ ] No
- [ ] Yes

4. Have you had "blackouts" or "flashbacks" as a result of drug use?

- [ ] No
- [ ] Yes

5. Do you ever feel guilty or bad about you drug use?

- [ ] No
- [ ] Yes

6. Does your spouse (or parents) ever complain about your involvement with drugs?

- [ ] No

- [ ] Yes

7. Have you neglected your family because of your use of drugs?

- [ ] No
- [ ] Yes

8. Have you engaged in illegal activities in order to obtain drugs?

- [ ] No
- [ ] Yes

9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?

- [ ] No
- [ ] Yes

Have you had medical problems as a result of your drug use (ex. memory loss, hepatitis, convulsions, bleeding, etc.)?

- [ ] No
- [ ] Yes

Comments:

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PHQ-2 Questionnaire

Patient Health Questionnaire 2 (PHQ-2)

Patient Name:

Date of Visit:

Client Questions

Over the past 2 weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things:

2. Not being able to stop or control worrying:

Questionnaire Score

Add up all the numbers for answers 1-2 above.
Total Score: