Willa mootk

Counseling Center

Alaska Screening Tool

Client Name: _____ **Client Number:** _____

Staff Name: _____ **Date:** _____

Info Received from: (include relationship to client} _____

Please answer these questions to make sure your needs are identified. Your answers are important to help us serve you better. If you are filling this out for someone else, please answer from their view. Parents or guardians usually complete the survey on behalf of children under the age of 13.

Section 1 - please estimate the number of days in the last two weeks *(enter a number 0-14 days)*		**Number of Days**
1	How many days have you felt little interest or pleasure in doing things?	
2	How many days have you felt down, depressed, or hopeless?	
3	Had trouble falling asleep or staying asleep or sleeping too much?	
4	Felt tired or had little energy?	
5	Had a poor appetite or ate too much?	
6	Felt bad about yourself or that you were a failure or had let yourself or your family down?	
7	Had trouble concentrating on things, such as reading the newspaper or watching TV?	
8	Moved or spoken slowly that other people could have noticed?	
9	Been so fidgety or restless that you were moving around a lot more than usual?	
10	Remembered things that were extremely unpleasant?	
11	Were barely able to control your anger?	
12	Felt numb, detached, or disconnected?	
13	Felt distant or cut off from other people?	

Section 2 - please check the answer to the following question based on your lifetime		**YES**	**NO**
14	I have lived where I often or very often felt like I didn't have enough to eat, had to wear dirty clothes, or was not safe		
15	I have lived with someone who was a problem drinker, or alcoholic, or who used street drugs		
16	I have lived with someone who was seriously depressed or seriously mentally ill		
17	I have lived with someone who attempted suicide or completed suicide		
18	I have lived with someone who was sent to prison		
19	I, or a close family member, was placed in foster care		
20	I have lived with someone while they were physically mistreated or seriously threatened		
21	I have been physically mistreated or seriously threatened. a. If you answered YES, did this involve your intimate partner (spouse, girlfriend, or boyfriend)		

Section 3 - Please answer the following questions based on your lifetime (D/N = Don't Know)		YES	NO	D/N
22	I have had a blow to the head that was severe enough to make me lose consciousness			
23	I have had a blow to the head that was severe enough to cause a concussion.			
	If you answered YES to 22 or 23, please answer a-c			
	a. Did you receive treatment for the head injury?			
	b. After the head injury, was there a permanent change in anything?			
	c. Did you receive treatment for anything that changed?			
24	Did your mother ever consume alcohol?			
	a. If **YES,** did she continue to drink during her pregnancy with you?			

Section 4 - please answer the following questions based on the past 12 months.		YES	NO
25	Have you had a major life change like death of a loved one, moving, or loss of a job?		
26	Do you sometimes feel afraid, panicky, nervous or scared?		
27	Do you often find yourself in situations where your heart pounds and you feel anxious and want to get away?		
28	Have you tried to hurt yourself or commit suicide?		
29	Have you destroyed property or set a fire that caused damage?		
30	Have you physically harmed or threatened to harm an animal or person in purpose?		
31	Do you ever hear voices or see things that other people tell you they don't see or hear?		
32	Do you think people are out to get you and you have to watch your step?		

Section 5 - Please answer the following questions based on the past 12 months.		YES	NO
33	Have you gotten into trouble at home, school, or in the community, because of using alcohol, drugs, or inhalants?		
34	Have you missed school or work because of using alcohol, drugs, or inhalants?		
35	In the past year have you ever had 6 or more drinks at any one time?		
36	Does it make you angery if someone tells you that you drink or use drugs, or inhalants too much?		
37	Do you think you might have a problem with alcohol, drugs, or inhalants use?		

Thank you for providing this information! Your answers are important to help us serve you better.