Adverse Childhood Experience (ACE) Questionnaire
Finding your ACE Score ra hbr 10 24 06

While you were growing up, during your first 18 years of life:

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?
   Yes No If yes enter 1 ________

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?
   Yes No If yes enter 1 ________

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?
   Yes No If yes enter 1 ________

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?
   Yes No If yes enter 1 ________

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?
   Yes No If yes enter 1 ________

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 ________

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?
   Yes No If yes enter 1 ________

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 ________

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes enter 1 ________

10. Did a household member go to prison?
    Yes No If yes enter 1 ________

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

Child and Adolescent Trauma Screen (CATS) - Youth Report

Name: ____________________ **Date:** ____________

Stressful or scary events happen to many people. Below is a list of stressful and scary events that sometimes happen. Mark YES if it happened to you. Mark No if it didn't happen to you.

1.	Serious natural disaster like a flood, tornado, hurricane, earthquake, or fire.	☐ Yes	☐ No
2.	Serious accident or injury like a car/bike crash, dog bite, sports injury.	☐ Yes	☐ No
3.	Robbed by threat, force or weapon.	☐ Yes	☐ No
4.	Slapped, punched, or beat up in your family.	☐ Yes	☐ No
5.	Slapped, punched, or beat up by someone not in your family.	☐ Yes	☐ No
6.	Seeing someone in your family get slapped, punched or beat up.	☐ Yes	☐ No
7.	Seeing someone in the community get slapped, punched or beat up.	☐ Yes	☐ No
8.	Someone older touching your private parts when they shouldn't.	☐ Yes	☐ No
9.	Someone forcing or pressuring sex, or when you couldn't say no.	☐ Yes	☐ No
10.	Someone close to you dying suddenly or violently.	☐ Yes	☐ No
11.	Attacked, stabbed, shot at or hurt badly.	☐ Yes	☐ No
12.	Seeing someone attacked, stabbed, shot at, hurt badly or killed.	☐ Yes	☐ No
13.	Stressful or scary medical procedure.	☐ Yes	☐ No
14.	Being around war.	☐ Yes	☐ No
15.	Other stressful or scary event?	☐ Yes	☐ No

Describe: ____

Which one is bothering you the most now? __________________

If you marked "YES" to any stressful or scary events, then turn the page and answer the next questions.

Mark 0, 1, 2 or 3 for how often the following things have bothered you in the last two weeks:

0 Never / 1 Once in a while / 2 Half the time / 3 Almost always

1.	Upsetting thoughts or pictures about what happened that pop into your head.	0	1	2	3
2.	Bad dreams reminding you of what happened.	0	1	2	3
3.	Feeling as if what happened is happening all over again.	0	1	2	3
4.	Feeling very upset when you are reminded of what happened.	0	1	2	3
5.	Strong feelings in your body when you are reminded of what happened (sweating, heart beating fast, upset stomach).	0	1	2	3
6.	Trying not to think about or talk about what happened. Or to not have feelings about it.	0	1	2	3
7.	Staying away from people, places, things, or situations that remind you of what happened.	0	1	2	3
8.	Not being able to remember part of what happened.	0	1	2	3
9.	Negative thoughts about yourself or others. Thoughts like I won't have a good life, no one can be trusted, the whole world is unsafe.	0	1	2	3
10.	Blaming yourself for what happened, or blaming someone else when it isn't their fault.	0	1	2	3
11.	Bad feelings (afraid, angry, guilty, ashamed) a lot of the time.	0	1	2	3
12.	Not wanting to do things you used to do.	0	1	2	3
13.	Not feeling close to people.	0	1	2	3
14.	Not being able to have good or happy feelings.	0	1	2	3
15.	Feeling mad. Having fits of anger and taking it out on others.	0	1	2	3
16.	Doing unsafe things.	0	1	2	3
17.	Being overly careful or on guard (checking to see who is around you).	0	1	2	3
18.	Being jumpy.	0	1	2	3
19.	Problems paying attention.	0	1	2	3
20.	Trouble falling or staying asleep.	0	1	2	3

Total Score____
Clinical = 15+

Please mark "YES" or "NO" if the problems you marked interfered with:

1. Getting along with others ☐ Yes ☐ No
2. Hobbies/Fun ☐ Yes ☐ No
3. School or work ☐ Yes ☐ No
4. Family relationships ☐ Yes ☐ No
5. General happiness ☐ Yes ☐ No

Consent for Release of Confidential or Protected Information

_________________________ (Name of consumer) ___________ (Record #) __________ (Date of birth) ___________________ (Social Security Number)

I authorize: **Gateway to Prevention and Recovery**
Name of Person or Facility Releasing Information

to release to: and ☐**exchange with:** (check if applicable)

____
Name of person / facility receiving information

1010 E 45th St Shawnee, OK 74804
Address of Person or Facility Releasing Information

____
Address of person or Facility Receiving Info

the following information for the following dates of treatment: ______________________________ (if known).

Method(s) by which information is to be released*:* __Mail __Fax __Verbal __Hand carried or given to consumer

In boxes below, I am indicating information to be disclosed from any medical/mental health/substance abuse records:		
__ Psychiatric Evaluation/Assessment __Assessment(s): Drug and Alcohol, ORAS __ Attendance __ Treatment plan/update __ Progress Reports / Recommendations	__ Discharge/Aftercare Plan __Release/Discharge Summary __ History & Physical Exam __ Letter of admit/discharge dates	__ Lab / X-ray reports __ Medications __ Diagnoses __ Billing/financial info

Other – List specific documents(s) or information: ______________________________
The records indicated above ☐can /or☐cannot contain Substance Use Disorder Information. ________Client Initials

Information is being released for the following purpose: reports and treatment planning______________________

I also understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it, and that in any event this authorization expires automatically as follows: upon discharge, or if unspecified, one (1) year after the patient's dated signature (below). Revocations should be submitted to the health information department where the information and appropriate revocation forms are kept.

I understand that my records are currently protected by Oklahoma State Statutes and federal privacy regulations including the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 160 & 164. I understand that my health information specified above will be disclosed pursuant to this authorization, and that the recipient of the information may redisclose the information and it may no longer be protected by the HIPAA privacy law. When applicable, the federal regulations governing the confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, prohibits redisclosure of such information without my specific written consent or when permitted by such regulations.

I understand that the covered entity and/or program seeking this authorization will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. I freely and voluntarily give this consent.

I understand that I am entitled to receive a copy of this authorization after it is signed.

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR NONCOMMUNICABLE DISEASE. *63 O.S. 1-502.2.B, eff. 11/1/2007)*

_________________________ /__________
Signature of consumer Date

_________________________ /__________
Witness (Optional) Date

_________________________ /__________
Signature of authorized representative or parent or guardian when required Date

____
Relationship to consumer

Consent to Treatment and Procedures

1) I understand that my records are protected by state and federal confidentiality laws. Privileged and confidential information will not be released to any person or entity not involved in my treatment without my written, informed consent with the following exceptions: - When released to medical personnel in a medical emergency - When I represent a danger to myself or someone else - When there is a suspicion of child abuse or neglect; Gateway is required by law to report to the Oklahoma Department of Human Services - When ordered by a court of competent jurisdiction - When a crime is committed on Gateway premises or against Gateway personnel - When Gateway records are reviewed by federal, state, or other entities which have the right of access to my information according to law. I have the right to revoke my consent at any time during treatment. I understand I may have legal consequences if I do. (Example: DHS, Probation, Drug Court, Community Sentencing, Prison Based Program, etc.)
2) I am aware of my client rights and responsibilities. I can obtain a full copy of OAC Title 450 Ch. 15 if I choose.
3) I am aware of the grievance procedure and can obtain guidelines for filing a grievance.
4) I am aware of the HIV/STD/AIDS/Hepatitis/Tuberculosis fact sheet and referral list.
5) I consent to Gateway using my own or child's Medicaid/SoonerCare number to bill for services. I also authorize Gateway to bill my insurance if needed.
6) I understand that I will not be turned away from services for not paying. However, I understand that I will not receive any completion certificates without having my balance paid in full.
7) I will not bring any weapons (concealed or not) onto any Gateway site.
8) I will not bring a camera, video camera, or sound recorder onto any Gateway site. I will not use a cell phone to make any phone calls, text, take pictures, or make video/audio recordings.
10) I understand that alcohol or illegal drugs/paraphernalia brought onto any Gateway site will be confiscated. I understand that Gateway has the right to notify law enforcement.
11) I understand that if I have a valid prescription to take medication, I will not take it onto any Gateway site, nor show/share this medication to other clients.
12) I understand that Gateway is a tobacco free facility.
13) I have been given a copy of the Informational Book, including general program rules, and I agree to abide by these rules and procedures.

I understand the purpose and nature of the services recommended, and I voluntarily consent to treatment.
I understand and agree to respect the privacy of others' identity, behavior, and statements.
I understand that my signature indicates that the above information was explained to my satisfaction.

CLIENT PRINTED NAME SIGNATURE DATE

PARENT/GUARDIAN PRINTED NAME SIGNATURE DATE

WITNESS PRINTED NAME SIGNATURE DATE

PARENT/GUARDIAN OBSERVATIONS

Check the items that apply to your child

FAMILY PROBLEMS	DISCIPLINE PROBLEMS
☐ Loss of interest in family activities	☐ Negative and argumentative
☐ Withdrawal from family members	☐ Overreacts to criticism
☐ Increased secretiveness	☐ Denies responsibility of any personal problems
☐ Comes in past curfew	☐ Defies rules
☐ Uses home as a stop-off place	☐ Abuse – verbal or physical
☐ Rejection of family standards and values	☐ Cheats on tests and/or homework
☐ Runaway	☐ Steals
☐ Suffered recent loss (moves, divorce, death)	**ACTIVITY LEVEL/EMOTIONAL TONE**
☐ Other siblings have problems	☐ Tired and lethargic
☐ Speaks angrily of or toward parents	☐ Seems unhappy or depressed
☐ Does not follow through on commitments to complete tasks	☐ Hyperactive and/or Excessive talking
☐ Troubles in the family (financial, emotional, health, separation, etc.)	☐ Class clown
RELATIONSHIPS/SOCIAL LIFE	☐ Seems overly anxious
☐ Sudden popularity	☐ Erratic behavior
☐ Avoids group activities	☐ Frequent mood swings
☐ Withdrawn and uncommunicative	**PHYSICAL APPEARANCE/COMPLAINTS**
☐ Sudden rejection by friends	☐ Moved toward an older social group
☐ Change in friends	☐ Poor personal appearance
☐ Moved toward a more negative group	☐ Physical bruises, lacerations, burn marks
☐ Moved toward an older social group	☐ Slurred speech
☐ Constant short phone calls	☐ Red, bloodshot eyes
☐ Callers hang up when adult answers	☐ Change in facial color
☐ Calls at odd hours of the night	☐ Complaints of physical problems or illnesses
DRUG AND/OR ALCOHOL USE	**DRUG-RELATED LIFESTYLE**
☐ Has come home high or drunk	☐ Wears drug-oriented clothing, apparel, symbols
☐ Has driven while high or drunk	☐ Smells of alcohol, marijuana, tobacco
☐ Has been sick or hung over	☐ Sudden changes in behavior
☐ Argues/fights/violent when using	☐ Has unexplained money
☐ Makes and breaks promises to quit using	☐ Constantly needs to borrow money
☐ Relatives and/or friends have commented on child's drug use	☐ Radical changes in number of material possessions, i.e. cell phones
☐ Blackouts	☐ Possesses alcohol, marijuana, tobacco products

DRUG USE, CON'T	SELF-HARM
Drugs known to use:	☐ Vague references to suicide plans ("I've taken care of things. I'm not going to be trouble to anyone anymore.")
Drugs suspected of using:	☐ Saying good-bye (suddenly telling friends how much they have enjoyed knowing them, giving away prized possessions, wishing them good luck in the years ahead)
Age first used:	☐ Talking about life after death
Currently using?	☐ Talking about people or pets who have died
Previous substance abuse treatment:	☐ Direct announcement of suicidal intentions (often disregarded as "attention-seeking")
Is school involved?	☐ Writing morbid material, suicide notes, poems

ADDITIONAL COMMENTS:

NAME OF CHILD: ____

NAME OF PARENT/GUARDIAN: ____

CHILD/ADOLESCENT PERSONAL HISTORY

CHILD'S NAME: ____ **DATE:** ___________________

FAMILY HISTORY

Birth mother: _________________________________Age:________ Highest grade completed:_______________

Occupation:____

Birth father:__________________________________Age:________ Highest grade completed:_______________

Occupation:____

Legal guardian (if different than birth parents):__________________________________Age: ________

Highest grade completed:________ Occupation:____

Step-parent:_____________________________________ Age: ________ Highest grade completed: ____________

Occupation: ____

Any other adults who have lived with and/or have been involved in raising the child

Name	Relationship	Age of child when adult was present

Child's siblings living in the home

Name	Gender	Age	Grade in School	Relationship to Child

DEVELOPMENTAL/PRENATAL HISTORY

Did mother use any legal/illegal substances (including tobacco/alcohol) during the pregnancy? [ ]Yes [ ] No

If yes, please provide details: ____

Did the mother experience complications during the pregnancy? [ ]Yes [ ]No

If yes, please provide details: ____

Were there any problems with the birth/postnatal period? [ ]Yes [ ]No

If yes, please provide details: ____

Was the child's development (age, motor, skills, verbal, etc.) within appropriate time frames? [ ]Yes [ ]No

If no, please provide details: ____

VISUAL/SPEECH/HEARING

Has the child

been prescribed glasses and or contact lenses? [ ]Yes [ ]No
been tested for language ability, including speech and hearing? [ ]Yes [ ]No
received speech therapy? [ ] Yes [ ] No
been in special classes for speech/hearing/visual impairment? [ ]Yes [ ]No

PHYSICAL HEALTH

Did the child have any significant health problems in the past? [ ]Yes [ ]No

If yes, please provide details: ______________________________

Does the child have any current health problems? [ ]Yes [ ]No

If yes, please provide details: ______________________________

Does the child currently take medications for physical ailments? [ ]Yes [ ]No If yes, please provide details:

MENTAL HEALTH

Has the child/adolescent had any mental/emotional/behavioral issues in the past (ADHD, depressed mood, violent outbursts, etc.)? [ ]Yes [ ]No
If yes, please provide details: ______________________________

Does the child/adolescent have any mental/emotional/behavioral problems which have been diagnosed by a qualified health provider? [ ]Yes [ ]No
If yes, please provide details: ______________________________

Is the adolescent currently taking medication for these issues? [ ]Yes [ ]No
If yes, please provide name of medication, name of doctor prescribing medication, dosage, and frequency:
____
Has the child been to counseling before? [ ]Yes [ ]No
If yes, please provide name of provider & agency:______________________________

SCHOOL NAME & STATE *if not Oklahoma*

PreK		
K		
1st Grade		
2nd Grade		
3rd Grade		
4th Grade		
5th Grade		
6th Grade		
7th Grade		
8th Grade		
9th Grade		

10th Grade		
11th Grade		
12th Grade		

What are average grades for the child? A B C D F

Does the child attend special education classes or IEP? [ ]Yes [ ]No

Please check the problems the child is currently having in school.

[ ] Not going to school [ ] Skipping classes [ ] Problems with students

[ ] Not understanding [ ] Failing to do homework [ ] Problems with teachers

CULTURAL/MORAL BELIEFS

Child's race/ethnicity (if Native American, please list tribe affiliation) ____

Is the child/family currently practicing religion? [ ]Yes [ ]No Please provide details: ___________________________

SEXUAL HISTORY

Has the child received any sex education at school or at home? [ ]Yes [ ]No

Do you have any concerns about the child's sexual development? [ ]Yes [ ]No

If yes, please provide details: ____

TALENTS/INTERESTS

What are some of the child's strengths, talents, and successes?

____

What are some of the child's hobbies, interests, and enjoyable activities?