

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 age 13.

SECTION I – Please estimate the number of days in the last 2 weeks

(enter a number from 0-14 days):

0-14 days

1. Over the last two weeks, 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 so 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 II – Please check the answer to the following questions based on your lifetime.

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 Yes No
15. I have lived with someone who was a problem drinker or alcoholic, or who used street drugs Yes No
16. I have lived with someone who was seriously depressed or seriously mentally ill Yes No
17. I have lived with someone who attempted suicide or completed suicide Yes No
18. I have lived with someone who was sent to prison..... Yes No
19. I, or a close family member, was placed in foster care..... Yes No
20. I have lived with someone while they were physically mistreated or seriously threatened..... Yes No
21. I have been physically mistreated or seriously threatened Yes No
 - a. If you answered "Yes", did this involve your intimate partner (spouse, girlfriend, or boyfriend)? Yes No

ALASKA SCREENING TOOL

SECTION III – Please answer the following questions based on your lifetime. (D/N = Don't Know)

22. I have had a blow to the head that was severe enough to make me lose consciousness Yes No D/N
23. I have had a blow to the head that was severe enough to cause a concussion. Yes No D/N
- If you answered "Yes" to 21 or 22, please answer a-c:**
- a. Did you receive treatment for the head injury? Yes No
- b. After the head injury, was there a permanent change in anything? Yes No D/N
- c. Did you receive treatment for anything that changed?..... Yes No
24. Did your mother ever consume alcohol? Yes No D/N
- a. **If Yes**, did she continue to drink during her pregnancy with you? Yes No D/N

SECTION IV – Please answer the following questions based on the past 12 months.

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

SECTION V – Please answer the following questions based on the past 12 months.

33. Have you gotten into trouble at home, at school, or in the community, because of using alcohol, drugs, or inhalants? Yes No
34. Have you missed school or work because of using alcohol, drugs, or inhalants? Yes No
35. In the past year have you ever had 6 or more drinks at any one time? Yes No
36. Does it make you angry if someone tells you that you drink or use drugs, or inhalants too much?..... Yes No
37. Do you think you might have a problem with your drinking, drug or inhalant use? Yes No

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

CLIENT STATUS REVIEW

Case Number:

Date completed: ___ / ___ / ___

Name _____

If you are filling this out for someone else, please answer from their view.

of Days

1. How many days during the past 30 days was your physical health (including physical illness and/or injury) **not good**? _____
2. How many days during the past 30 days was your mental health (including depression and/or problems with emotions, behavior, or thinking) **not good**? _____
3. How many days during the past 30 days did poor physical or mental health keep you from doing your usual activities, such as taking care of yourself, work, or recreation? _____
4. How many days during the past 30 days have you had thoughts about suicide or hurting yourself? _____
5. How many days during the past 30 days have you used alcohol? _____
6. How many days during the past 30 days have you used illegal drugs (including medications not as prescribed/directed)? _____
7. In the past 30 days, how many times have you used emergency medical services such as the hospital, emergency room, emergency medical technicians or health aides for physical, substance abuse, or mental health problems? _____
8. Which one of the following best describes your housing situation? (please check one)
 - Adult in private residence – independent living (house, apartment, trailer, hotel, room, etc.)
 - Adult in private residence – dependent living (house, apartment, trailer, hotel, room, etc.)
 - Child living with family/extended family or with non-relative
 - Foster home/foster care
 - Homeless or shelter
 - Jail or correctional facility
 - Crisis residence (short term stabilization)
 - Residential care facility (assisted living, halfway house, group homes, board & care)
 - Residential treatment facility for:
 - Mental health
 - Substance abuse
 - Co-occurring disorder
 - Institutional care facility – 24 hour, 7 days/week (nursing facilities/homes, psychiatric health facilities, hospitals)
 - Other (please describe) _____
9. If you are a student (attending elementary through high school), which one of the following best describes your school?
 - Public/private school
 - Home schooledIf you attend a public/private school, how many days have you been absent during the past 30 school days? _____
10. Which one of the following best describes your employment status? (please check one)
 - Employed full time working for money (30 or more hours per week including supported employment)
 - Employed part time working for money (less than 30 hours per week including supported employment)
 - Unemployed (looking for employment during the past 30 days or on layoff from a job)
 - Not in labor/work force (not looking for employment during the past 30 days); if you checked this box, please check one of the following:
 - Homemaker
 - Retired
 - Engaged in subsistence activities
 - Other (please describe) _____
 - Student
 - Disabled
 - Inpatient/inmate (otherwise unable to enter labor force)
 - Job training program
 - Volunteer
11. In a typical **week** over the past 30 days, how many hours were you engaged in productive activities (e.g., school, employment, volunteering in community service, subsistence activities, etc.)? Total hours: _____
12. In the past 30 days, have you had any legal involvement? (Legal charges, court appearance, arrests, probation, parole) Yes No

CLIENT STATUS REVIEW

Case Number:

13. In the past 30 days, have you been arrested?..... Yes No
14. In the past 30 days, have you had an intimate partner slap, punch, shove, kick, choke, hurt, or threaten you? Yes No
15. In the past 12 months, have you been arrested?..... Yes No

16. Below are questions about your life. Please answer each question by putting an X in the space that best describes how you feel about each issue. Please use only **one X** for each question.

How do you feel about:	 Terrible	 Unhappy	 Dissatisfied	 Mixed	 Satisfied	 Pleased	 Delighted
Your housing?							
Your ability to support your basic needs of food, housing, etc.?							
Your safety in your home or where you sleep?							
Your safety outside your home?							
How much people in your life support you?							
Your friendships?							
Your family situation?							
Your sense of spirituality, relationship with a higher power, or meaningfulness of life?							
Your life in general?							

17. Who filled out this survey? (please check one)
- I filled this out by myself I filled this out for a child
- Someone helped me fill this out (Person's name) _____

18. Please respond to these statements if you have received services from this agency.

How do you feel about the services you received?
(Place an X in the space that best describes your level of agreement with each statement)

	 Terrible	 Unhappy	 Dissatisfied	 Mixed	 Satisfied	 Pleased	 Delighted
I was treated with respect.							
I was able to get all the services I needed.							
The services improved the quality of my life.							

19. What did you like about the services you received? _____

20. What did you dislike about the services you received? _____

