Southwest Youth & Family Services, Inc. Date: _____

Client Information

Name: _____ Maiden: _____
First Middle Last

Date of Birth: _____ SSN: _____

Age: _____ Race: _____ Gender: *Male* *Female*

Household Information

Phone: _____ Phone: _____

Address: _____

Please provide the following information for each person who lives at this address.

Name	Age	Relationship

Person to Contact In Case of Emergency

Name: _____ Relationship: _____

Address: _____

Phone: _____ Phone: _____

Please explain why you are seeking services:

What are your immediate and urgent needs?

Name of Probation Officer(s): _____

Name of DHS Caseworker(s): _____

Client Name: _____ Date: _____ **Page 2**

Financial Information

Please indicate how much income your household receives from each source on a monthly basis.

	Monthly		Annual
Employment		**Staff will total and calculate annual.**	
Spouse/S.O. Employment			
Child's Employment			
Social Security			
TANF			
Child Support/Alimony			
Gambling/Lottery			
Rental Property			
Unemployment			
Worker's Comp			
Military			
Retirement			
Other			
Total			

Please indicate how income was verified.

Two Recent, Consecutive Pay Check Stubs	☐	☐	Federal Form W-2 (1 year FTE)
Verification of Income from Current Employer	☐	☐	Medicaid Card
Government Document Verifying Income	☐	☐	Federal Income Tax Return
Signed Income Statement If Other Verification Not Available*		☐	

**I, _____, affirm that the income information provided above is true and accurate and that I am unable to provide any other source of income verification other than this statement because _____.*

Client Signature: _____ Staff Signature: _____

Insurance Information

Provider: *SoonerCare* *Medicare* *Private/Other:* _____

MHSAS *Insure Oklahoma* *None*

Member ID: _____

Staff Only HH#: _____

Client is at or below 200% of Federal Poverty Level.	**Yes**	**No**
Client is uninsured/underinsured for needed behavioral health services.	**Yes**	**No**
Client does not meet Medicaid eligibility criteria.	**Yes**	**No**

Mental Health Screening Form III

Instructions: In this program, we help people with all their problems, not just their addictions. This commitment includes helping people with emotional problems. Our staff is ready to help you to deal with any emotional problems you may have, but we can do this only if we are aware of the problems. Any information you provide to us on this form will be kept in strict confidence. It will not be released to any outside person or agency without your permission. If you do not know how to answer these questions, ask the staff member giving you this form for guidance. Please note, each item refers to your entire life history, not just your current situation, this is why each question begins - "Have you ever ...."

1. Have you ever talked to a psychiatrist, psychologist, therapist, social worker, or counselor about an emotional problem? YES NO

2. Have you ever felt you needed help with your emotional problems, or have you had people tell you that you should get help for your emotional problems? YES NO

3. Have you ever been advised to take medication for anxiety, depression, hearing voices, or for any other emotional problem? YES NO

4. Have you ever been seen in a psychiatric emergency room or been hospitalized for psychiatric reasons? YES NO

5. Have you ever heard voices no one else could hear or seen objects or things which others could not see? YES NO

6. (a) Have you ever been depressed for weeks at a time, lost interest or pleasure in most activities, had trouble concentrating and making decisions, or thought about killing yourself? YES NO

   (b) Did you ever attempt to kill yourself? YES NO

7. Have you ever had nightmares or flashbacks as a result of being involved in some traumatic/terrible event? For example, warfare, gang fights, fire, domestic violence, rape, incest, car accident, being shot or stabbed? YES NO

8. Have you ever experienced any strong fears? For example, of heights, insects, animals, dirt, attending social events, being in a crowd, being alone, being in places where it may be hard to escape or get help? YES NO

9. Have you ever given in to an aggressive urge or impulse, on more than one occasion that resulted in serious harm to others or led to the destruction of property? YES NO

10. Have you ever felt that people had something against you, without them necessarily saying so, or that someone or some group may be trying to influence your thoughts or behavior? YES NO

11. Have you ever experienced any emotional problems associated with your sexual interests, your sexual activities, or your choice of sexual partner? YES NO

Client Name/ID#:_____ Date:_____

12. Was there ever a period in your life when you spent a lot of time thinking and worrying about gaining weight, becoming fat, or controlling your eating? For example, by repeatedly dieting or fasting, engaging in much exercise to compensate for binge eating, taking enemas, or forcing yourself to throw up?
    YES NO

13. Have you ever had a period of time when you were so full of energy and your ideas came very rapidly, when you talked nearly non-stop, when you moved quickly from one activity to another, when you needed little sleep, and believed you could do almost anything? YES NO

14. Have you ever had spells or attacks when you suddenly felt anxious, frightened, and uneasy to the extent that you began sweating, your heart began to beat rapidly, you were shaking or trembling, your stomach was upset, you felt dizzy or unsteady, as if you would faint? YES NO

15. Have you ever had a persistent, lasting thought or impulse to do something over and over that caused you considerable distress and interfered with normal routines, work, or your social relations? Examples would include repeatedly counting things, checking and rechecking on things you had done, washing and rewashing your hands, praying, or maintaining a very rigid schedule of daily activities from which you could not deviate. YES NO

16. Have you ever lost considerable sums of money through gambling or had problems at work, in school, with your family and friends as a result of your gambling? YES NO

17. Have you ever been told by teachers, guidance counselors, or others that you have a special learning problem? YES NO

Print client's name: _____

Date: _____

Reviewer's comments: _____

_____

Total Score: _____
(Each yes = 1 point)

Client Name/ID#: _____ Date: _____

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.

Client Name:_____ Date:_____

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

CATS 7-17 Years Score <15	CATS 7-17 Years Score 15-20	CATS 7-17 Years Score 21+
Normal. Not clinically elevated.	Moderate trauma-related distress.	Probable PTSD.

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

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

Child and Adolescent Trauma Screen (CATS) - Caregiver Report (Ages 7-17 years)

Child's Name: _____ **Date:** _____

Caregiver Name: _____

Stressful or scary events happen to many children. Below is a list of stressful and scary events that sometimes happen. Mark YES if it happened to the child to the best of your knowledge. Mark No if it didn't happen to the child.

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 the family.	☐ Yes	☐ No
5.	Slapped, punched, or beat up by someone not in the family.	☐ Yes	☐ No
6.	Seeing someone in the 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 his/her private parts when they shouldn't.	☐ Yes	☐ No
9.	Someone forcing or pressuring sex, or when s/he couldn't say no.	☐ Yes	☐ No
10.	Someone close to the child 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 the child most now? _____

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

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

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

1. Upsetting thoughts or images about a stressful event. Or re-enacting a stressful event in play.	0	1	2	3
2. Bad dreams related to a stressful event.	0	1	2	3
3. Acting, playing or feeling as if a stressful event is happening right now.	0	1	2	3
4. Feeling very emotionally upset when reminded of a stressful event.	0	1	2	3
5. Strong physical reactions when reminded of a stressful event (sweating, heart beating fast).	0	1	2	3
6. Trying not to remember, talk about or have feelings about a stressful event.	0	1	2	3
7. Avoiding activities, people, places or things that are reminders of a stressful event.	0	1	2	3
8. Not being able to remember an important part of a stressful event.	0	1	2	3
9. Negative changes in how s/he thinks about self, others or the world after a stressful event.	0	1	2	3
10. Thinking a stressful event happened because s/he or someone else did something wrong or did not do enough to stop it.	0	1	2	3
11. Having very negative emotional states (afraid, angry, guilty, ashamed).	0	1	2	3
12. Losing interest in activities s/he enjoyed before a stressful event. Including not playing as much.	0	1	2	3
13. Feeling distant or cut off from people around her/him.	0	1	2	3
14. Not showing or reduced positive feelings (being happy, having loving feelings).	0	1	2	3
15. Being irritable. Or having angry outbursts without a good reason and taking it out	0	1	2	3
16. Risky behavior or behavior that could be harmful.	0	1	2	3
17. Being overly alert or on guard.	0	1	2	3
18. Being jumpy or easily startled.	0	1	2	3
19. Problems with concentration.	0	1	2	3
20. Trouble falling or staying asleep.	0	1	2	3

CATS 7-17 Years Score <15	CATS 7-17 Years Score 15-20	CATS 7-17 Years Score 21+
Normal. Not clinically elevated.	Moderate trauma-related distress.	Probable PTSD.

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

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

Client Name:_____

Caregiver Name:_____ Date:_____

asQ Suicide Risk Screening Tool

Ask Suicide-Screening Questions

Client Name:_____ Date:_____

Ask the patient:

1. **In the past few weeks, have you wished you were dead?** ❍ Yes ❍ No
2. **In the past few weeks, have you felt that you or your family would be better off if you were dead?** ❍ Yes ❍ No
3. **In the past week, have you been having thoughts about killing yourself?** ❍ Yes ❍ No
4. **Have you ever tried to kill yourself?** ❍ Yes ❍ No

   If yes, how? _____

   _____

   _____

   When? _____

   _____

If the patient answers **Yes** *to any of the above, ask the following acuity question:*

5. **Are you having thoughts of killing yourself right now?** ❍ Yes ❍ No

   If yes, please describe: _____

Next steps:

- If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (**Note: Clinical judgment can always override a negative screen*).
- **If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity:**
  - ☐ **"Yes"** to question #5 = **acute positive screen** (imminent risk identified)
    - **Patient requires a STAT safety/full mental health evaluation. Patient cannot leave until evaluated for safety.**
    - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.
  - ☐ **"No"** to question #5 = **non-acute positive screen** (potential risk identified)
    - **Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. Patient cannot leave until evaluated for safety.**
    - Alert physician or clinician responsible for patient's care.

Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text "HOME" to 741-741

Client Name:_____ Date:_____

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