CO-OCCURRING CONDITIONS
SCREENING FORM

Client Name: _____ Program: _____

SECTION I	YES √	NO √
1. In the past year, have you been diagnosed by a doctor with a mental health condition such as anxiety, depression, bipolar, psychosis, or any other emotional conditions? If yes, specify:		
2. Are you currently taking any medication(s) for mental health or emotional issues? (i.e., Prozac, Paxil, Zoloft, Wellbutrin, Serzone, Lithium, Klonopin, Trazadone, Xanax, Valium, Risperdal, Zyprexa, Clozapine, Depakote, Neurontin, Mellaril, etc.). List medications you take:		
SECTION II		
3. In the past year, have you had any serious thoughts, plans, or attempts of suicide, or serious plans to harm others? If yes, explain:		
4. Have you ever been treated for serious mental health problems? If yes, where (i.e., crisis house, hospital, clinic, etc.)?		
5. Do you receive SSI or SSDI for mental health or emotional problems?		
6. Do you have a history of chronic relapses or failed attempts at sobriety?		
SECTION III		
7. Before you were using any alcohol or drugs, or after you were clean from alcohol and other drugs for 60 days, have you ever:		
A. Felt so depressed that you had difficulty taking care of yourself, going to work or school, or keeping up with family responsibilities?		
B. Felt extreme panic around other people or in public places, or been completely unable to leave the house for a noticeable length of time?		
C. Seen or heard things that other people didn't see or hear, such as seeing shadows or hearing voices telling you what to do?		
D. Felt suspicious of other people, believing that they were following you or spying on you, or talking about you, or were going to harm you?		
E. Believed that someone could control your mind by putting thoughts into or taking thoughts out of your head?		
F. Do things repeatedly in order to keep something bad from happening (i.e., counting, re-checking the door locks, frequent hand-washing, or other rituals)?		
G. Had a period of a week or more when you didn't need to sleep, had constant racing thoughts, or go on spending or sexual binges?		
H. Had unwanted, repeated thoughts or nightmares of a traumatic event that made you feel just as anxious, scared, or numb as when the event happened?		

Client Signature: _____ Date: _____

---------- *For staff use only*----------

CO-OCCURRING CONDITIONS SCORING FORM

DIRECTIONS: For each section, count the number of "yes" answers and put that number by the corresponding score.	
SECTION I: GENERAL SIGNS **1** *"yes" to any question in this section **plus 1** from another section **may** indicate a need for referral.* *A "yes" in this section is not necessarily an automatic referral point, but should be considered in the referral decision process (use your clinical judgment).*	**SCORE: _____**
SECTION II: Serious Indicators Of The Need For Further Assessment *If **1** from this section is present, it **may** mean that referral is important to determine the client's stability level.* *If **1** from this section is combined with any **1** of Section III, referral is **strongly recommended**.*	**SCORE: _____**
SECTION III: Specific Disorder Indicators *If **1** from this section with no score in any other section, a referral for assessment **may** be made during the course of treatment for consultation and/or assessment.* *If **2 or more** from this section are marked, referral to a dual diagnosis program is **recommended**, and **strongly recommended** when combined with a score in Section II.*	**SCORE: _____**

NOTES:

Section 1, Question #1: If clients states "no" to this question, then ask: Have you ever been diagnosed by a doctor with anxiety, depression, bi-polar, psychosis, or other emotional issues?

Section I, Question #2: If client states they are currently taking no medications for mental health or emotional issues, then ask: Have you ever in your lifetime taken medications for mental health or emotional issues? If yes, what are they and how long did you take each?

Section II, Question #3: If client states that in the past year they have had serious thoughts, plans, or attempts of suicide or serious plans to harm others, then ask how recently and get detailed information.

Section III, Question #7: If client says they have never had a sustained period of sobriety, ask client if they have ever experienced the symptoms listed in A-H.

Observations / Comments: _____

_____

_____

_____

Referral(s) made: _____

Staff Signature: _____ Date: _____