**Patient Name:** ______________________________ **DOB:** ____________________ **Date:** __________

# Ace Identified

Did you feel like you didn't have enough to eat, had to wear dirty clothes, or had no one to protect or take care of you?

○ Yes ○ No

Did you lose a parent through divorce, abandonment, death or other reason?

○ Yes ○ No

Did you live with anyone who was depressed, mentally ill or attempted suicide?

○ Yes ○ No

Did you live with anyone who had a problem with drinking or using drugs, including prescription drugs?

○ Yes ○ No

Did your parents or adults in your home ever hit, punch, beat, or threaten to harm each other?

○ Yes ○ No

Didi you live with anyone who went to jail or prison?

○ Yes ○ No

Did a parent or adult in you home ever swear at you, insult you, or put you down?

○ Yes ○ No

Did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way?

○ Yes ○ No

Did you feel that no one in your family loved you or thought you were special?

○ Yes ○ No

Did you experience unwanted sexual contact (such as fondling or oral/anal/vaginal intercourse/penetration)?

○ Yes ○ No

Do you believe that these experiences have affected your health?

○ Not Much ○ Some ○ A lot