

MILLER CARE GROUP
MICHAEL S MILLER DO FACOS CWS PC

Dear New Patient:

We would like to welcome you to the Miller Care Group. Our staff looks forward to caring for your medical needs.

During this initial visit one of our staff members will copy your picture ID and insurance card. We will also follow an insurance claim for you.

Per our Patient Financial Policy, you will be required to pay your office visit co-pay at the time of your visit. Our office accepts All Major credit/debit cards and cash. We no longer accept checks as a form of payment. Our office accepts Medicare, Indiana Medicaid, Anthem BCBS, most Healthy Indiana Plans (HIP 2.0) as well as many other commercial insurance plans. We however do not accept **MDWise, IU Health and most Humana plans including Humana Medicare.**

It is the patients responsibility to verify with your insurance carrier that the provider you are seeing is in your network. If you have questions about your coverage, please contact your insurance carrier.

Remember, your insurance plan is between you and your insurance carrier. any unpaid balance will be your responsibility.

Thank you for giving us the opportunity to treat you. We look forward to helping you with all of your medical needs. We appreciate your interest in our practice.

Please feel to contact us with any questions or concerns you may have.

Yours in Health

Dr. Michael Miller and the Health Care team Miller Care Group

MILLER CARE GROUP INTAKE SHEET

First: _____ MI: _____

Last: _____

Sex M F SSN: _____

DOB: _____

Phone Number with Area Code: _____

Secondary Phone Number with Area Code: _____

Address: _____

City _____ State: _____ Zip Code: _____

Marital Status: Married Single Divorced Widowed

Spouses Name: _____

Spouses Phone number with Area Code: _____

email address: _____

Employer: _____

Occupation: _____

Primary Care Physician: _____

Phone Number with Area Code: _____

Preferred Pharmacy Name: _____

Location: _____

Phone Number with Area Code: _____

Insurance Type: _____

Policy Number: _____

Phone Number: _____

Policy Effective Date: _____

Emergency Contact: _____

Relationship: _____

Phone Number with Area Code: _____



MICHAEL MILLER DO, FACOS, FAPWCA, WCC,

**Miller Care Group
Patient Financial Policy**

Thank you for choosing us as your specialty health care provider. We are committed to building a successful physician-patient relationship with you, and your family. Please understand that payment for services is part of that relationship. Our reception staff is trained to inform you of the financial policies of this practice. This document must be read, and signed by each patient. It will remain in effect for all services rendered during your time as a patient in our practice.

INFORMATION: A current registration will be on file in the patient chart during time that the patient is considered active. Patient registration will be updated yearly, and will include numbers for the patient including home phone, cell phone, and work phone. A signature by the responsible party is required. On an annual basis, or as needed, we will ask for a photocopy of your insurance card for your file.

Your insurance policy is a contract between you, and your insurance company. We cannot bill your insurance carrier unless you give us your insurance information. Failure to provide us with accurate information can result in denied claims, which are then the responsibility of the patient.

Insurance Claims: I am authorizing Miller Care Group (MCG), to furnish information to insurance carriers concerning the illness or medical treatment of dependents or myself. I hereby assign to the provider all insurance payments for medical services rendered to myself or my dependent, except those services which I have already paid for prior to the filing of the insurance claim. I also acknowledge responsibility for payment of all medical fees regardless of any insurance I may have to assist me in the responsibility.

Primary Insurance: Miller Care Group (MCG) will file your medical claim upon proof of insurance (i.e. insurance card). As part of your insurance contract, full payment for "your part" of the charges is expected from you at the time of service. "Your part" of charges incurred is defined as any co-pays, deductibles or non-covered service charges that are incurred on the date of service. Be prepared to pay your co-pay at the time of service. If you have insurance coverage, but cannot provide documentation of the insurance policy, payment is due in full at the time of service.

Please be aware that some, and in rare cases, all, of the services provided may be non-covered services, and not considered payable under your insurance plan. You need to contact your insurance carrier prior to your appointment for your coverage benefits.

Secondary Insurance: Claims will be filed with secondary insurance if adequate information is received at the time of service.

PATIENT FINANCIAL RESPONSIBILITY: If no insurance is to be filed by MCG, or if MCG is not a participating provider in your insurance network, and you do not have out of network benefits, full payment is due at the time of service unless other arrangements have been made. A finance charge of 1% monthly will be applied to any balance left unpaid after 60 days of receipt of insurance payment.





MICHAEL MILLER DO, FACOS, FAPWCA, WCC,

MINORS/DEPENDANTS: Children under the age of 18 will require the signature of a responsible adult party on the registration form. An adult is required to accompany children under the age of 18 to all office visits.

METHOD OF PAYMENT: Acceptable methods of payment are cash, check, Visa, MasterCard, and debit. Any returned check will result in an additional fee of \$25.

ACCOUNTS PAST DUE: Payment is due on the day services are rendered. Payment for any additional treatment supplies, are due the day they are received. Noncompliance may result preparation of account for small claims court, collection agency, and-or credit bureau reporting, and possible discharge from the practice.

In the event that an account is turned over for collection, the person financially responsible for the account will be responsible for the cost of collections, which includes, but is not limited to, late fees, collection agency fees, court costs, interest and fines.

A patient may remit in full to the collection agency all-outstanding charges owed on account, include amounts previously place with the collection service. Under theses circumstances, a physician may reserve the right to re-establish the patient to active status in the practice.

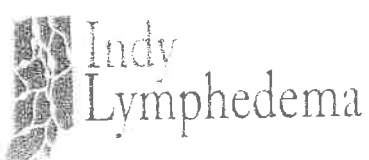
MISSED APPOINTMENTS: Appointments missed, and not cancelled prior to 24 hours will be charged a "no show" fee of \$40.00. If a new patient misses two (2) consecutive appointments, no additional appointments will be made. If an established patient misses and/or cancels with less than 24 hours notice four (4) times, the patient may be discharged from the practice.

Your signature below indicates that you accept, and understand this policy. Further, your signature authorizes Miller Care Group to release such medical information necessary to process you r insurance claims (if any). You herein authorize payment of medical benefits to MCG when an assigned claim is filed.

I have received a copy of the Miller Care Group financial policy.

Printed Patients Name	Signature of patient (Or responsible party)	Date

******Miller Care Group is legally known as Michael S. Miller, DO FACOS PC, LLC******



HEALTH HISTORY

FAMILY HEALTH HISTORY

HAS ANYONE IN YOUR FAMILY HAD:

	MOTHER	FATHER	SIBLINGS	NONE
DIABETES	_____	_____	_____	_____
HEART PROBLEMS	_____	_____	_____	_____
STROKE	_____	_____	_____	_____
HIGH BLOOD PRESSURE	_____	_____	_____	_____

MEDICATIONS

<u>MEDICATION NAME</u>	<u>DOSAGE</u>	<u>FREQUENCY</u>	<u>ROUTE</u>

SURGICAL HISTORY

ALLERGIES: PLEASE LIST

CURRENT USE OF THE FOLLOWING DRUGS PLEASE CIRCLE

- | | |
|-----------|-----------------|
| None | Cocaine |
| Morphine | Methamphetamine |
| Marijuana | Heroin |

Do you have a history of drug dependency? Is so, please list the drugs you had an addiction to.

SOCIAL HISTORY

Alcohol Use: Please circle appropriate

- | | |
|---|--|
| None | Heavy Drinker(more than 2 drink/day) |
| Abstainer (fewer than 12 drinks per year) | Binge Drinker(drinks occasionally w/5+ drinks per session) |
| Light Drinker(1-13 drinks per month) | History of Alcoholism |
| Moderate Drinker(more than 14 drinks per month) | |

ARE YOU A SMOKER? PLEASE CIRCLE

- NON-SMOKER
- PREVIOUS SMOKER
- 1-3 CIGARETTES PER DAY
- UP TO 1 PACK PER DAY
- 2 OR MORE PACKS PER DAY

NOTIFICATION OF INSURANCE CHANGES

IT IS THE RESPONSIBILITY OF THE PATIENT OR PATIENTS FAMILY TO INFORM OUR OFFICE OF CHANGES TO HEALTH INSURANCE COVERAGE.

FAILURE TO INFORM OUR STAFF OF A CHANGE IN INSURANCE WILL RESULT IN CHARGES BEING DENIED FOR PAYMENT OR PAYMENT REDUCED AND THE PATIENT OR PATIENTS FAMILY BEING RESPONSIBLE FOR 100% PAYMENT OF THE DENIED CHARGES.

PLEASE NOT WE DO NOT ACCEPT THE FOLLOWING INSURANCES:

HUMANA, HUMANA MEDICARE, IU HEALTH PLANS AND SOME ANTHEM BCBS MEDICARE PLANS, MDWISE.

ALL INSURANCE IS SUBJECT TO VERIFICATION.

I UNDERSTAND THAT I AM RESPONSIBLE FOR KEEPING MY INSURANCE INFORMATION CURRENT WITH DR. MICHAEL MILLER/MILLER CARE GROUP. I UNDERSTAND THAT IF MY INSURANCE INFORMATION CHANGES AND I DO NOT INFORM THE STAFF THAT I WILL BE RESPONSIBLE FOR ALL CHARGES INCURRED.

PATIENTS PRINTED NAME

PATIENTS SIGNATURE

DATE

MILLER CARE GROUP
INDY TRANSITIONS
DR. MICHAEL S MILLER
8355 ROCKVILLE RD SUITE 120
INDIANAPOLIS, IN 46234
PHONE: 317-429-0061 FAX: 317 222-1953

In compliance with the BitterPill.in.gov policy and the Affordable Care Act, as well as the ICD-10 implementation, proper coding has been increased in scope. All results of our urine drug testing required by Indiana House Bills 246 and 844 will be coded for any and all findings. This may involve perceived higher risk to insurers inclusive of, but not limited to, all illicit drugs under the Indiana Law, as well as alcohol use, which may be inter active with any other prescribed or illicit drug findings. Insurance carriers, law enforcement, and prescribers of any controlled substance will need to know more about the results of these tests and records which must be reflected in patients medical records and these should be considered part of your permanent medical records.

These can also be reviewed and correlated with other required state reported information on controlled substances and may not be as completely private as you may think.

Signature

Date

REQUEST FOR MEDICAL RECORDS

TO: _____

PROVIDER/HOSPITAL: _____

PATIENT NAME (PLEASE PRINT)

AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS, TO INCLUDE:

FULL RECORD _____

LABS/RADIOLOGY _____

LIMITED RELEASE (SPECIFY INFORMATION
NEEDED) _____

PATIENT DOB: _____

PATIENT SSN: _____

PATIENT SIGNATURE: _____

PLEASE RELEASE INFORMATION TO:

DR. MICHAEL S MILLER

8355 ROCKVILLE RD SUITE 120

INDIANAPOLIS, IN 46234

FAX: 317-222-1953

EFFECTIVE OCTOBER 11, 2016

Our office will no longer process re-fill requests or requests for new prescriptions on Friday.

All prescription requests must be made at least 48 hours in advance to allow processing time for our staff.

Please be sure you have an adequate supply of your medication at all times.

Please note that requests for controlled substance prescriptions or pain medications are not considered an emergency and will be subject to the 48 hour notice. These will not be processed on Friday.

Thank You

**Patient Health Questionnaire-9
(PHQ-9)**

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use a check mark to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or hurting yourself in some way	0	1	2	3

FOR OFFICE CODING _____ + _____ + _____ + _____
= Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

LEVEL 2—Substance Use—Adult*
 *Adapted from the NIDA-Modified ASSIST

Name: _____ Age: _____ Sex: Male Female Date: _____

If the measure is being completed by an informant, what is your relationship with the individual receiving care? _____

In a typical week, approximately how much time do you spend with the individual receiving care? _____ hours/week

Instructions: On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that *during the past 2 weeks* you (the individual receiving care) have been bothered by “using medicines on your own without a doctor’s prescription, or in greater amounts or longer than prescribed, and/or using drugs like marijuana, cocaine or crack, and/or other drugs” at a slight or greater level of severity. The questions below ask how often you (the individual receiving care) have used these medicines and/or substances during the past 2 weeks. Please respond to each item by marking (✓ or x) one box per row.

During the past TWO (2) WEEKS , about how often did you use any of the following medicines ON YOUR OWN , that is, without a doctor’s prescription, in greater amounts or longer than prescribed?						Clinician Use	
		Not at all	One or two days	Several days	More than half the days	Nearly every day	Item Score
a.	Painkillers (like Vicodin)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
b.	Stimulants (like Ritalin, Adderall)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
c.	Sedatives or tranquilizers (like sleeping pills or Valium)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
Or drugs like:							
d.	Marijuana	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
e.	Cocaine or crack	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
f.	Club drugs (like ecstasy)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
g.	Hallucinogens (like LSD)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
h.	Heroin	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
i.	Inhalants or solvents (like glue)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
j.	Methamphetamine (like speed)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
						Total Score:	

Courtesy of National Institute on Drug Abuse.
 This Instrument may be reproduced without permission by clinicians for use with their own patients.

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____ Age: _____ Sex: Male Female Date: _____

If this questionnaire is completed by an informant, what is your relationship with the individual? _____
 In a typical week, approximately how much time do you spend with the individual? _____ hours/week

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

	During the past TWO (2) WEEKS , how much (or how often) have you been bothered by the following problems?	None Not at all	Slight Rare, less than a day or two	Mild Several days	Moderate More than half the days	Severe Nearly every day	Highest Domain Score (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	

Miller Care Group
8355 Rockville Road Ste 120
Indianapolis IN 46234
Phone: 317-429-0061 Fax: 317-222-1953

Psychosocial Questionnaire and Assessment

Client Name: _____ Therapist: _____
 Client Age: _____ Date of Birth: _____ Date of Intake _____

Describe the problem or situation that brought you to counseling:

When did you first notice the problem? _____
 How often is the problem occurring? _____

Please indicate the problems that you are experiencing:

- | | | |
|-----------------------------|--------------------------|-----------------------------|
| Anger _____ | Excitability _____ | Mania _____ |
| Alcohol problems _____ | Fatigue _____ | Numb feelings _____ |
| Anxiety _____ | Gambling problems _____ | Obsessive _____ |
| Appetite disturbance _____ | Hallucinations _____ | Panic attacks _____ |
| Avoiding people _____ | Heart palpitations _____ | Phobias/fears _____ |
| Compulsive behavior _____ | Hopeless feelings _____ | Recurrent thoughts _____ |
| Depressed mood _____ | Hyperventilating _____ | Relationship problems _____ |
| Disorganized thoughts _____ | Impulsivity _____ | Self harm _____ |
| Distractible _____ | Irritability _____ | Sexual problems _____ |
| Dizziness _____ | Judgment errors _____ | Sleep problems _____ |
| Drug problems _____ | Loneliness _____ | Suicidal thoughts _____ |
| Eating habits _____ | Memory problems _____ | Worry _____ |
| Elevated mood _____ | Mood changes _____ | Other (specify) _____ |

Briefly explain if/how the problems are effecting your life (Work, school, relationships, etc.):

List stressful situations, events, experiences and other relevant information over the past 12 months that may be contributing to the problem(s):

Please describe any trauma (extremely stressful events) that you can recall experiencing at any time of your life. This may include experiencing or witness to physical, emotional, psychological and/or sexual abuse, being involved in very high stress situations for long periods of time, involved in accidents, witness to sudden death, military combat situations, etc.:

What are your personal strengths (skills, talents, gifts, traits, etc.)?

Who do you turn to for support (specific individuals, groups, church, etc.)?

What are your goals for therapy?

Family of Origin:

Who were (are) your primary caregivers? _____

Describe your relationship with your caregivers:

Do you have Siblings? Please give names and ages and a brief description of the quality of the relationship:

Has anyone in your family of origin (parents, grandparents, siblings, etc.) ever suffered from mental health problems? Please indicate who and the extent of the known problem:

Other relevant family of origin history: _____

Marital and Current Family/Relationship Dynamics:

Single _____

Married _____ Spouse's name and length of marriage _____

Divorced _____ Name(s) of former spouse(s) and dates of marriage(s) _____

Widowed _____ Please indicate length of marriage, spouses name and date of death _____

Current committed relationship, not married _____ Cohabiting? _____

Please indicate name of partner and length of relationship _____

Children (names and ages) _____

Medical History

Do you have a primary care physician? No _____ Yes _____

Name and Location of primary physician: _____

Any other physicians involved with your care? _____

Please describe any significant physical health problems:

Current medications, doses, other treatments and purpose:

Psychological/Mental Health History

Please describe any past mental health diagnosis, approximate dates when diagnosed, previous hospitalizations, psychiatric treatment etc:

Current psychiatric or psychotherapeutic treatments and providers involved:

Current medications including doses and prescribing physician:

Chemical Use History

Please check the following substances that you have used in the past 1 year.

Alcohol ___ Marijuana ___ Cocaine/Crack ___ Meth ___ Inhalants ___ Stimulants ___
Hallucinogens ___ Heroin/Opiates ___ Prescription pain medications or other narcotics
(indicate) _____ Other _____

How many times per week/month do you use alcohol? _____

How many times per week/month do you use other drugs? (please list drug and
frequency) _____

How many servings do you have at a time? _____

Have you ever felt like you should cut down on your drinking or drug use? _____

Have people ever annoyed you by criticizing your drinking or drug use? _____

Have you ever felt guilty about your drinking or drug use? _____

Have you ever had a drink or used drugs first thing in the morning in order to get started for
the day, steady your nerves, or get rid of a hangover or residual drug effect? _____

Have you ever been in trouble with the law as a result of your chemical use? _____

Have you ever been treated for chemical abuse/dependency? Yes _____ No _____

If yes, indicate dates and facilities _____

Is there a family history of chemical abuse/dependency? Yes _____ No _____

If yes, please specify _____

Education History

How many years of formal education do you have? _____

High School Diploma _____ B.A. /B.S. degree(s) _____

Graduate degree(s) _____ Other: _____

Are you currently in school? _____ What school do you attend? _____

Is the current problem effecting your academic performance? Yes _____ No _____

If yes, please describe: _____

Have you been diagnosed with a learning disability (describe)? _____

Have you been diagnosed with ADD/ADHD? _____

Work History

Are you currently working? Yes _____ No _____

What type of work do you do? _____

Past work experiences _____

Have there been any recent changes to your employment status? _____

Has the current problem affected your work performance? If yes, please describe:

Military History

Have you ever been in the military? Yes _____ No _____ Active? _____

What branch? _____ Please describe any combat experience and location: _____

Type of discharge _____ Rank at discharge _____

Recreation

Describe activities that you do as a form of recreation or relaxation: _____

Describe activities and interests that you wish to further develop: _____

Spiritual/Religious

Do you associate with a particular spiritual or religious denomination or group?

No _____ Yes _____ (please specify) _____

Is the current problem affecting your spiritual life? No _____ Yes _____ (explain) _____

Would you like to incorporate your spiritual beliefs in therapy? No _____ Yes _____

Please describe how we may help integrate your faith into therapy _____

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