FRESNO AMERICAN INDIAN HEALTH PROJECT
DOCUMENT CHECKLIST FOR HEALTH RECORDS

Client Name and Date of Birth: _____

Chart Number: _____

ADULT REGISTRATION
Check each item that is in the client's records.
Blank spaces indicate that the document is not present or needs to be updated.
Bold items are required in order to complete client registration.

DATE: _____

____ **Informed Consent and Disclosure**

____ **Client Intake Registration Form**

____ **Client's Rights and Responsibilities**

____ **Health Assessment Form**

____ **Notice of Privacy Practices Notification**

____ **Service Access Form**

____ **ACE Questionnaire**

____ **Drivers' License or California Identification Card**

____ **Social Security Card**

____ **Tribal Enrollment Letter or Card**

____ **Income Verification** (Last 6 months—i.e. pay stubs, notice of action, food stamp cards)

____ **Medi-Cal/ Medi-Care Card/ Private Insurance Card**

____ Birth Certificate (children)

____ Immunization Record (children 0-17)

____ List of Prescription Medications (If client is taking any)

____ List of over the counter Medications (Tylenol, Vitamins, Tums, Herbs, Teas)

Registration Complete Staff Initials: _____

FRESNO AMERICAN INDIAN HEALTH PROJECT

1551 E. Shaw Ave., Suite 139 Fresno, CA 93710 • Phone (559) 320-0490 Fax (559-320-0494

INFORMED CONSENT AND DISCLOSURE OF SERVICES

I understand that the services provided by Fresno American Indian Health Project include direct services as well as referral and linkage services. FAIHP staff will work with the clients to secure services and funding available from various resources outside of FAIHP. FAIHP does not guarantee payment for services that are referred to an appropriate health or substance abuse treatment provider.

Initials _____ I understand that this consent acknowledges my participation in the services provided by FAIHP & requires the discussion of my health conditions and health needs with a FAIHP staff member.

Initials _____ I authorize FAIHP Staff to provide the necessary or advisable health screening, assessments and evaluations for the purpose of providing direct services and linkage/referral services for:

[ ] Myself_____(Print Name)

[ ] My Child_____(Print Child's Name)

Initials _____ I understand that some or all of my/my child's personal health information may be shared among FAIHP Professional Staff and outside Service Providers in order to link me/my child to the appropriate services and to provide active case management services.

Initials _____ I understand that I will not be charged for Direct Services provided by FAIHP.

Initials _____ I understand that FAIHP is not responsible for fees to outside service providers unless I obtain a written referral/authorization for payment from my Case Manager prior to service.

Patient Release of Information

I,_____hereby authorize Fresno American Indian Health Project to request and receive copies of my medical information for any services that I receive from outside service providers. I understand that this information will be used to update my records at FAIHP and to provide appropriate Case Management follow-up and referral services. I further understand and agree that requests for specific information regarding HIV/AIDS status and/or treatment, treatment for drug, alcohol or substance abuse and information related to the treatment of mental health, developmental or psychiatric conditions require a separate consent.

Signed:_____ Date: _____

Witness/Case Manager: _____ Date: _____

FAIHP
Fresno American Indian Health Project

HRN: _____
Received By: _____
Date Entered: _____

Client Registration Form

PLEASE PRINT CLEARLY

Date:_____/_____/_____

Client's Legal Name: _____

AKA (also known as):_____PCP (Primary Care Provider): _____

Date of Birth:_____/_____/_____ SSN__-_____-_____Last Well Physical____/_____/___

Gender: ☐ Male ☐ Female ☐ Other Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow

Are you currently homeless: ☐ Yes ☐ No Are you currently residing in a temporary living facility: ☐ Yes ☐ No

Home Address: _____

Mailing Address (If different than home):_____

City/State/Zip Code:_____

Preferred Phone#:_____Secondary Phone#: _____

Are you currently working: ☐ Part time ☐ Full time ☐ Unemployed Occupation: _____
Would you like to receive the monthly Newsletter Y / N

E-mail Address: _____

CalWorks Y / N **Tribal Tanif** Y / N **Single Parent Home** Y / N **Two Parent Home** Y / N **Number of Children**_____

Preferred Method of Communication and Reminders: ☐Phone ☐E-Mail ☐Mail ☐Text ☐ Opt Out of reminders

Race: (Select all that apply) ☐ American Indian/Alaskan Native ☐ Asian ☐Native Hawaiian/ Pacific Islander
☐ White ☐ Black/African American ☐ Hispanic

Is Client a US Veteran? ☐ Yes ☐ No Separation Date: _____

If American Indian/ Alaskan Native: Tribe:_____Enrollment #:_____

If you are not American Indian/ Alaskan Native, are you a member of an Indian Household? ☐ Yes ☐ No

Number of People in Household (Immediate family only): _____
Household Income (Monthly): _____Source:

In Case of Emergency

Primary Contact Name:_____Relationship:_____
Preferred Phone#:_____SecondaryPhone#:_____
HomeAddress: _____City/State/Zip_____
Primary Language_____ Secondary Language_____ Interpreter Required Y / N

Name of Pharmacy: Address: Phone#:

Bring all your medications to each medical appointment. I give permission to perform reasonable and necessary medical examinations, including photos for consultation and/or examination, testing, and treatment. By signing, you are indicating that you understand that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended, along with potential risks and benefits. The consent will remain fully effective until it is revoked in writing. You have the right at any time to ask additional questions or to discontinue or decline services.

Client signature (or Parent/Legal Guardian if applicable) Date Review by: FAIHP Staff

FAIHP
Fresno American Indian Health Project

Rights and Responsibilities

This statement shall not preclude FAIHP from emphasizing services for the American Indian/Alaska Native community.

CLIENTS HAVE THE RIGHT TO:

- Receive assistance in a prompt, courteous, and responsible manner.
- Be treated with dignity and respect.
- Be free from verbal, emotional, physical abuse and/or inappropriate sexual behavior.
- Complete privacy and **confidentiality** in accordance with Title 42, Code of Federal Regulation Part 2, except in cases of threat to self, others, child abuse, elder or dependent adult abuse, or court order.
- Know titles and qualifications of all who provide your care.
- Obtain complete and current information concerning diagnosis, treatment, and prognosis in terms the client can be reasonably expected to understand.
- Participate in decisions regarding care, including information about any proposed treatment or procedure in order to give consent or refusal, unless the health or safety of self or others is being compromised or the client is in an altered state.
- Refuse treatment to the extent permitted by law, and to be informed of the health care consequences of such action.
- Leave the premises even against the advice of their clinician.
- Be accorded access or copy to his/her file within a reasonable timeframe with written authorization.
- Review and request changes or amendments to his/her file with written request.
- Be informed of the costs associated with treatment upon request.
- Revoke his/her authorization to release information, except to the extent the action has not already been taken.
- Expect reasonable response to all requests for services and receive clear explanations for any services that cannot be provided. Seek clarification and understanding of your care.
- Expect reasonable continuity of care and to know in advance the time and location of appointments.
- Know what the program rules and regulations are that apply to his/her participation in the program.
- Be advised if the provider proposes to engage in research or perform experimentation that in any way affects their care, and may refuse to participation in such experimental research.

- Ask about reasonable alternatives to care outside our facilities or request a second professional opinion.
- Be accorded safe and comfortable accommodations to meet his or her needs.
- Appeal a discharge or file a complaint with the Program Director according to the grievance procedure. *(This information is available at the front desk).*
- Information about knowledge, skills, and credential of clinician(s).

CLIENTS HAVE THE RESPONSIBILTY TO:

- Provide accurate and complete information concerning health history, financial status, insurance coverage, and/or any other information required by FAIHP in order to provide services.
- Inform FAIHP and/or referring facilities if you are unable to keep any appointments 24 hours prior to the scheduled appointment.
- Request further information concerning anything you do not understand, notify us if conditions worsen, or if an unexpected reaction occurs seek immediate assistance.
- Express opinions, concerns, or complaints in a constructive manner to the appropriate staff.
- Treat the staff, other clients, and property of FAIHP in a respectful and courteous manner.
- Follow all rules and guidelines for program participation and use of the FAIHP facilities.

FAIHP HAS THE RIGHT TO:

- Refuse service to any client who is verbally or physically abusive, threatening, and/or creating a hostile environment with inappropriate or sexual comments to any staff member or other client(s) on the phone or in person as specified by FAIHP guidelines.
- Refuse service to any client who we suspect is under the influence of alcohol, drugs or other substance.
- Suspend or terminate services of any client who does not comply with the guidelines or rules that are outlined for use of FAIHP programs or facilities.

FAIHP
Fresno American Indian Health Project

Rights and Responsibilities

Acknowledgement Receipt

I have reviewed the Rights and Responsibilities; I understand what my rights and responsibilities are as described above, Furthermore, I understand that I may file a grievance using FAIHP procedures* if I feel these rights have been violated.

Self/Parent/Guardian Signature _____ **Date** _____

*The Grievance Policy and Comment Forms are available at the front desk upon request.

This statement shall not preclude FAIHP from emphasizing services for the American Indian/Alaska Native community.

Fresno American Indian Health Project Adult Initial Health Assessment

Name:

What services did you need today?

Primary Care Provider: Last visit date:

Birth Date:	Birth Place:
Weight	Height:
Sex:	Gender Identity:

Sexual Orientation:

Allergies:

Health History: (Check all that apply)

Have you ever had or ever been diagnosed with any of the following:

( ) Respiratory Illness, Asthma, Emphysema or Chronic bronchitis
( ) Head Injury resulting in loss of consciousness
( ) Kidney stones, kidney infections of bladder infections
( ) Positive PPD Test For TB Date:
( ) Hospitalized due to surgery, illness or injury
( ) Diabetes: Type 1, Type 2, or during pregnancy Date diagnosed:
( ) Been told you have a thyroid or other glandular disease
( ) Have you been diagnosed with any mental health illness
( ) Blood clots in your legs or elsewhere that required medical attention
( ) History of any other illness that require regular medical attention
( ) Have you ever been tested for hepatitis C Date:
( ) Have you ever had an HIV test Date:
( ) Involuntary weight loss of 10 or more pounds within the last 3 months
( ) Pneumonia vaccination Date:
( ) Flu Shot Date:
( ) Other:

( ) Heart Disease
( ) Heart Attack Date:
( ) Chest Pain or Angina
( ) Shortness of Breath
( ) Stroke Date:
( ) Rectal Bleeding
( ) Abnormal Vaginal Bleeding
( ) Arthritis or Joint Problems
( ) History of Cancer
( ) Any Physical Disabilities
( ) Tuberculosis
( ) High Blood Pressure
( ) History of colonoscopy Date:
( ) Blood, Sugar or Protein in Urine

If you checked any of the above diagnoses please provide additional information:

_____

_____

Family History

Check all items that apply to blood relatives (parents, grandparents, siblings)

( ) Heart Disease	( ) Stroke	( ) Mental Illness
( ) High Blood Pressure	( ) Bleeding Disorders	( ) Suicide
( ) Cancer	( ) Liver and kidney Problems	( ) Asthma
( ) Alcoholism	( ) Seizures Disorder	( ) Drug Abuse
( ) Mental Retardation	( ) Diabetes Who:	( ) Other:

If you checked any of the above diagnoses please provide additional information:

_____

Women:

Are you Currently Pregnant? Yes / No Due Date:_____
If yes, have you received pre-natal care? Yes / No
Number of Pregnancies: _____
Number of Live Birth(s): _____
History of Abortion or Miscarriage? Yes / No Dates:_____

Do you practice Breast Self Exam? Yes / No
Last Clinical Breast Exam: Date:_____
Last Mammogram: Normal/ Abnormal Date:_____
Last Pap / Pelvic Exam: Normal/Abnormal Date:_____

Men:

Last Prostate Exam: Normal/Abnormal Date:_____
Last Testicular Exam: Normal/Abnormal Date:_____

Fresno American Indian Health Project Adult Initial Health Assessment

Eyes, Ears, Dental

Do you wear or need to wear glasses or contact lenses? Yes/No
When was your last eye exam?_____
Do you wear or need to wear hearing aids? Yes/No
Do you currently have any dental or tooth pain? Yes/No
If yes please explain:_____
When was the last time you had a dental exam?_____
Do you wear dentures? Yes/No
When was the last time you were fitted for your dentures? Date:_____

Health and Behavior Patterns

Please circle any of the following symptoms or difficulties that apply to you:

Headaches	Dizziness	Tremors
Stomach Troubles	Fatigue	Irritability
Palpitations	Anger	Financial Problems
Feel Tense	Feel Panicky	Difficulty Concentrating
Over Ambitious	Can't Make Decisions	Bad Home Conditions
Sexual Problems	Memory Problems	Bowel Disturbances

Have you ever hurt yourself or attempted suicide? Yes / No Date:
Have you ever hurt someone else? Yes / No Date:

Alcohol use Yes / No Socially only Yes / No Drinks per Week:
Have you ever felt the need to Cut down on your drinking?
Have people Annoyed you by criticizing your drinking?
Have you ever felt bad or Guilty about your drinking?
Have you ever needed an Eye opener the first thing in the morning to steady your nerves or get rid of a hangover?

Tobacco Use: (Please Circle)

Smoking:	None / Previous / Current	Packs per day:
Smokeless:	None / Previous / Current	Amount per day:
Vape:	None / Previous / Current	Times a day:

Drug Use: (Please Circle) No / Previous / Current Amount per week:
Type of Drug:
Route of Administration:
Have you ever used needles to inject medications or drugs? Yes / No
Do you use a latex condom during sex (Prevent STI & HIV)? Yes / No
Do you use a condom every time you have sex? Yes / No
Are you using Family Planning? Yes / No Specify Method:

Over the past two weeks, how often have you been bothered by any of the following problems?

1. Little interest of pleasure in doing things?
( )Not at all ( ) Several Days ( ) More than half the days ( ) Nearly everyday

2. Feeling down, depressed of hopeless?
( )Not at all ( ) Several Days ( ) More than half the days ( ) Nearly everyday

Exercise and Activity Patterns

Type of Activity:
Number of days per week: Amount of time per week:
How many hours do you spend sitting per day? (Please Circle) 0-3 4-6 7+

(Please Circle)	Sleep patterns:	Poor	Fair	Good	Hours per night:
	Energy level:	Low	Fair	Good	

Spiritual Practice

What is your religious preference:_____

Have you ever participated in Native American ceremonial activities? Yes/ No

Do you think that cultural or spiritual activities will benefit your health & wellness? Yes/ No

Do you attend church, Native American church or ceremony regularly? Yes/ No

Are you interested in participating in cultural ceremonies such as sweat lodge, purification ceremony or Pow Wow? Yes/No

Family Safety

Has a family member/intimate partner threatened your safety, insulted, put-down or degraded you?

Yes/No How Recent:

Has a family member/intimate partner ever hit, slapped, punched, kicked, shoved, grabbed, or pulled your hair?

Yes/No How Recent:

Has a family member/intimate partner ever forced you to engage in any type of sexual activity against your will?

Yes/No How Recent:

Do you currently feel afraid for your safety? Yes / No If yes offer BH services / Mandated Reporting

Home Safety Information

Do you have smoke detectors in your home or apartment? Yes / No (If no please make referral)

Do you have a car child safety seat? Ages 0-9 Yes / No / Not Applicable

Is medication and cleaning supplies locked in cabinets? Yes / No

Are emergency phone numbers posted? Yes / No

Is there a gun in your house? Yes / No

If so, is the gun in a locked cabinet? Yes / No / Not Applicable

Client Authorization:

I acknowledge that the information provided is correct regarding my health and behaviors. I further give authorization and consent that my health assessment and treatment plan may be discussed confidentially among health professionals within Fresno American Indian Health Project in order to determine the best/most appropriate treatment plan for me.

Client Name	Client/ Guardian Signature	Date

Reviewed by Intake Specialist:

Name	Signature	Date

Reviewed by Health Care Provider:

Name	Signature	Date

FRESNO AMERICAN INDIAN HEALTH PROJECT.
Notice of Privacy Practices

This notice summarizes how medical information about you may be used and disclosed and how you can get access to this information.

Your provider will discuss this information with you and you will be given a copy of the complete Privacy Notice. Please ask your provider any questions you have or if you do not understand your privacy rights.

PLEASE REVIEW IT CAREFULLY.

Fresno American Indian Health Project
1551 E. Shaw Ave., Suite 139
Fresno, CA 93710

SUMMARY OF YOUR PRIVACY RIGHTS

I. Understanding Your Health Record Information

Each time you visit a Fresno American Indian Health Project facility for services, a record of your visit is made. If you are referred by FAIHP through a program, FAIHP also keeps a record. Typically, this record contains your symptoms, examination, test results, diagnoses, treatment, and a plan for future care. This information, often referred to as your health record, serves as a:

- Plan for your care and treatment.
- Communication source between health care professionals.
- Means used by Medicare, Medicaid, private insurance or FAIHP to verify the services billed.
- Tool for education of health care professionals.
- Source of data for research, facility and program planning.
- Legal document that describes the care you receive.

Understanding your health record and how the information is used helps you to:

- Ensure its accuracy.
- Better understand why others may review your health information.
- Make an informed decision when authorizing disclosures.

II. Your Health Information Rights

Although your health record is the physical property of the Fresno American Indian Health Project the information belongs to you.

You have the right to:

- **Inspect and receive a copy of your health record**.
- **Request a restriction** on certain uses and disclosures of your health information. If FAIHP agrees to your request, we will comply with your request unless the information needed to provide you with emergency services.
- **Request a correction/amendment to your health record**.
- **Request confidential communications about your health information.** You may ask that we communicate with you at a location other than your home.
- **Receive a listing of certain disclosures FAIHP has made** of your health information upon request.
- **Revoke your written authorization to use or disclose health information**. This does not apply to health information already disclosed or used or in circumstances where we have taken action on your prior authorization.

III. FAIHP Responsibilities

Fresno American Indian Health Project is required by law to:

- Maintain the privacy of your health information.
- Inform you about our Privacy Practices regarding health information we collect and maintain about you.
- Notify you if we are unable to agree to a requested restriction.
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.
- Honor the terms of this notice or any subsequent revisions of this notice.

FAIHP reserves the right to change its Privacy Practices and to make the new provisions effective for all protected health information it maintains. If FAIHP makes any significant changes to this Notice, we will make the notice of change public. FAIHP also will post any revised Notice of Privacy Practices at public places in its health care facilities and on its web site at www.faihp.org or you may also request a copy of the notice be sent to you. FAIHP understands that health information about you is personal and is committed to protecting your health information. **FAIHP will not use or disclose your health information without your permission, except as described in this notice and as permitted by the Privacy Act.**

IV. How FAIHP may use and disclose health information about you.
The following categories describe how we may use and disclose health information about you.

- **In order to provide your treatment.**
- **For the payment of services you receive.**
- **For normal health care operations and conducting routine business.**
- **To Business Associates /MOU Providers so they may provide you services.**
- **Notification/Communication with Family if they are responsible for your treatment.**
- **Uses and Disclosures about the Deceased.**
- **To notify you of Treatment Alternatives and Other Health Benefits and Services.**
- **To contact you for Appointment Reminders.**
- **Public Health: FAIHP may use or disclose your health information to public health or other appropriate government authorities as follows:**
  (1) FAIHP may use or disclose your health information to government authorities that are authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or conducting public health surveillance, investigations, and interventions.
  (2) FAIHP may disclose your health information to government authorities that are authorized by law to receive reports of child abuse or neglect.
  (3) FAIHP may disclose your health information to government authorities that are authorized by law to receive reports of other abuse, neglect, or domestic or if FAIHP may disclose your health information if you may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition.
- **Law Enforcement** as authorized by law or in response to a court order.
- **Health Oversight Authorities:** These oversight activities include: investigations, audits, inspections and other actions. These are necessary for the government to monitor the health care system, government benefit programs, and entities subject to government regulatory programs and/or civil rights laws for which health information is necessary to determine compliance.
- **Compelling Circumstances** affecting the health or safety of an individual.
- **Non-Violation of this Notice: <u>FAIHP is not in violation of this Notice</u>** or the HIPAA Privacy Rule if any of its employees or its contractors (business associates) discloses protected health information under the following circumstances:
  (1) **Disclosures by Whistleblowers:** If a FAIHP employee or contractor (business associate) in good faith believes that FAIHP has engaged in conduct that is unlawful or otherwise violates clinical and professional standards or that the care or services provided by FAIHP has the potential of endangering one or more patients or members of the workplace or the public and discloses such information.
  (2) **Disclosures by Workforce Member Crime Victims:** Under certain circumstances, a FAIHP workforce member (either an employee or contractor) who is a victim of a crime on or off the facility premises may disclose information about the suspect to law enforcement official provided that:
    a. The information disclosed is about the suspect who committed the criminal act.
    b. The information disclosed is limited to identifying and locating the suspect.

Any other uses and disclosures will be made only with your written authorization, which you may later revoke in writing atany time.

To Exercise Your Rights
To exercise your rights under this Notice, to ask for more information, or to report a problem regarding your Privacy Rights, contact the Services Program Director or Chief Executive Officer at Fresno American Indian Health Project.

If you believe your Privacy Rights have been violated,
You may file a written complaint with:

The California Area Office of Indian Health Service
650 Capitol Mall
Sacramento, CA 95814

or

The Secretary of Health and Human Services
U.S. Department of Health and Human Services
Washington, D.C. 20201.

There will be no retaliation for filing a complaint.

Fresno American Indian Health Project

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT RECEIPT

I hereby acknowledge that I have received a copy of the Fresno American Indian Health Project (FAIHP) Notice of Privacy Practices.

Print Name of Client	Client Signature	Date

Or

Print Name of Client Representative	Representative's Signature	Date

If Client is Unable to Acknowledge Receipt of Privacy Notice

I hereby certify that the client was unable to acknowledge receipt of the FAIHP Notice of Privacy Practices because:

Print Name of FAIHP Staff	Staff Signature	Date

Fresno American Indian Health Project

Service Access Permission Form

PROTECTEDHEALTHINFORMATION

Please indicate below any persons and/or organizations that are permitted to coordinate care on your behalf.

☐ I do not wish to list any individuals or organizations.

NAME: _____
RELATIONSHIP: _____
PHONE NUMBER: _____ Date of Birth: _____
EXCEPTIONS: _____
_____

NAME: _____
RELATIONSHIP: _____
PHONE NUMBER: _____ Date of Birth: _____
EXCEPTIONS: _____
_____

NAME: _____
RELATIONSHIP: _____
PHONE NUMBER: _____ Date of Birth: _____
EXCEPTIONS: _____
_____

ORGANIZATION:

☐ CVIH Behavioral Health
☐ CVIH Medical
☐ OVCDC
☐ Other: _____
☐ Medicine Shoppe
☐ North Fork TANF
☐ Sierra Tribal Consortium

_____ _____
Patient Name (PRINT) Patient Date of Birth

_____ _____
Signature: Patient/Personal Representative Date

_____ _____
Name of Patient Guardian/Conservator Relation to Patient or Authority to Act

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