



BRIGHT STAR COMMUNITY CARE

ADVERSE CHILDHOOD EXPERIENCES (ACEs) QUESTIONNAIRE Prior to your 18th birthday

	Yes	No
1. Emotional Abuse – Did a parent or adult in the house hold often or very 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?	<input type="checkbox"/>	<input type="checkbox"/>
2. Physical Abuse – Did a parent or other adult in the household often or very often Push, grab, slap, or throw something at you? Or even hit you so hard that you had marks or were injured?	<input type="checkbox"/>	<input type="checkbox"/>
3. Sexual Abuse – 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 attempt or actually have oral, anal, or vaginal intercourse with you?	<input type="checkbox"/>	<input type="checkbox"/>
4. Emotional Neglect – Did you often or very 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?	<input type="checkbox"/>	<input type="checkbox"/>
5. Physical Neglect – Did you often or very often feel that ... you didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? Or did it seem as though your parents or guardian didn't take care of you, ie. Take you to the doctor if you needed to go etc.?	<input type="checkbox"/>	<input type="checkbox"/>
6. Loss of Parent – Was a biological parent ever lost to you through divorce, abandonment, or other reason?	<input type="checkbox"/>	<input type="checkbox"/>
7. Domestic Violence – Was your parent or guardian: Often or very often pushed, grabbed, slapped, or had something thrown at them? Or Sometimes often, or very often kicked, bitten, hit with a fist, or hit with something hard? Or repeatedly hit for at least a few minutes or threatened with a gun/knife?	<input type="checkbox"/>	<input type="checkbox"/>
8. Family Member with Addiction – Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs or inappropriately used prescription drugs?	<input type="checkbox"/>	<input type="checkbox"/>
9. Family Member with Depression or Mental Illness – Was a household member depressed or mentally ill, or did they attempt suicide?	<input type="checkbox"/>	<input type="checkbox"/>
10. Family Member Incarceration – Did a household member go to prison?	<input type="checkbox"/>	<input type="checkbox"/>