

## Adverse Childhood Experiences (ACEs)

While you were growing up, during your first 18 years of life:

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| 1. Did a parent or other adult in the household often or very often:   | YES | NO |
| Swear at you, insult you, put you down, or humiliate you <b>OR</b> act in a way that made you afraid that you might be physically hurt?  |     |    |
| 2. Did a parent or other adult in the household often or very often:   | YES | NO |
| Push, grab, slap, or throw something at you <b>OR</b> hit you so hard that you had marks or were injured?  |     |    |
| 3. Did an adult or person at least 5 years older than you ever:  | YES | NO |
| Touch or fondle you or have you touch their body in a sexual way <b>OR</b> attempt or actually have oral, anal, or vaginal intercourse with you?   |     |    |
| 4. Did you often or very often feel that:  | YES | NO |
| No one in your family loved you or thought you were important or special <b>OR</b> your family didn't look out for each other, feel close to each other, or support each other?  |     |    |
| 5. Did you often or very often feel that:  | YES | NO |
| You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you <b>OR</b> your parents were too drunk or high to take care of you or take you to the doctor if you needed it?  |     |    |
| 6. Was your mother or stepmother or father or stepfather:  | YES | NO |
| Often or very often pushed, grabbed, slapped, or had something thrown at her/him <b>OR</b> sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard <b>OR</b> ever repeatedly hit for at least a few minutes or threatened with a knife or gun? |     |    |
| 7. Were your parents ever separated or divorced?   | YES | NO |
| 8. Did you live with anyone who was a problem-drinker or alcoholic or who used street drugs or prescription drugs not as prescribed?   | YES | NO |
| 9. Was a household member depressed or mentally ill or did a household member attempt suicide?   | YES | NO |
| 10. Did a household member go to prison?   | YES | NO |