



# Gambling Assessment

\*\*\*\*

## Presenting Problem

How did you hear about our program? \_\_\_\_\_

Describe what is happening in your life that helped you make the decision to enter treatment at this time: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How do you see gambling directly affecting your life? Example: not doing things with family, using household funds to gamble etc.? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Has your gambling impacted anyone else besides yourself? \_\_\_\_\_

\_\_\_\_\_

## Gambling History

Overview of gambling history (first experience, big win, life events, affects on self, family, work, health etc.) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Which pattern of gambling most describes you?

\_\_\_\_\_ Regular gambler – gambles some every month - including those who might be in early remission, have not gambled in the past 30 days but when gambling gambled some every month.

\_\_\_\_\_ In the past 12 months able to maintain 30 or more days abstinence with lapses into 14 to 180 day gambling episodes

\_\_\_\_\_ In the past 12 months maintains abstinence for 30 days or more but has lapses into 1 to 14 day episodes.

What ways have you tried in the past to stop gambling? \_\_\_\_\_

\_\_\_\_\_

Were any of them helpful?  Yes  No If yes which ones? \_\_\_\_\_

## Intrapersonal Issues

### Physical Health

How would you describe your health on a scale of 1 to 10, 10 being the Best you have ever felt.

Scale: 1 2 3 4 5 6 7 8 9 10

Counselor's observation of patient's physical health: Poor Average Good Excellent

Current medications prescribed for medical purposes and over the counter drugs used, including vitamins and herbal medications: \_\_\_\_\_

\_\_\_\_\_



**Weight:** Client's report: underweight, or overweight. By # of lbs. \_\_\_\_\_

**Patient's nutritional status:** # of meals a day \_\_\_\_\_. Do you eat a balanced diet? Yes No

Do you have difficulty with shopping, cooking or hygiene? Yes No

**Sleep Patterns:** Do you have a regular bedtime and wake up time? Yes No Sleeps \_\_\_\_\_ hours per night. Do you feel rested when you wake up? Yes No Do you take naps regularly during the day? Yes No

Do you have any other medical conditions? Yes No If yes what \_\_\_\_\_

Do you have a primary care physician? Yes No If yes – Name \_\_\_\_\_ Date last seen \_\_\_\_\_

Do you have any limitations that impact daily activities? Yes No If yes what? \_\_\_\_\_

**Pain Issues:** What is your current level of pain (0-to-10, with 0 =None, 10 = Worst)? \_\_\_\_\_. How long have you been having this pain? \_\_\_\_\_. Describe the probable source of the pain you are having. \_\_\_\_\_

**Mental Health or other Emotional Issues**

Have you ever had a significant period in which you experienced the following?

- Anxiousness/nervousness       Grief and loss issues       Inability to comprehend       Sleep disturbances
- Loss of appetite       Serious depression       Isolation       Loss of motivation
- Numb (no emotional life)       Lonely       Eating disorder(s); if checked;       Anorexia,  Bulimia
- Anger       Hostility/violence       Self-esteem problems       Shyness
- Shame       Stress       Boundaries ( too passive - too aggressive)
- Phobias/paranoia/delusions       Clouded or confused thinking       Trouble with writing
- Hallucinations. if checked, also note: Audio Visual.       Trouble with reading
- Other(s): \_\_\_\_\_

What is the patient's rating of their mental health?  Poor       Average       Good  Excellent

Counselor's rating of the patient's mental health?  Poor       Average       Good  Excellent

Do you like yourself?  Yes  No Explain: \_\_\_\_\_

Is there anything you did in your past that still bothers you today?  No Yes, if yes: Describe: \_\_\_\_\_

**Suicide Ideation/Attempts**

Do you have a family history of suicide?  Yes  No If yes explain: \_\_\_\_\_

Have you ever (past or present) thought about committing suicide?  Yes  No If yes date of last thought: \_\_\_\_\_

Do you have a current plan to harm yourself?  Yes  No If yes evaluate level of risk.

Current Level of RISK: None 1 2 3 4 5 6 7 8 9 10 **If risk is above a 5 then a No-Harm Contract must be signed. If risk is above an 8 and client is unable to contract for safety call a CDMHP.**

**Violence/Abuse History**

Do you have homicidal thoughts?  Yes  No If yes explain: \_\_\_\_\_

Do you have a history of combative or assaultive behavior?  Yes  No If yes explain: \_\_\_\_\_

Have you ever been *physically* abused?  Yes  No If yes explain: \_\_\_\_\_

Have you received counseling for this issue?  Yes  No If yes, by whom: \_\_\_\_\_

Have you ever been *sexually* abused?  Yes  No If yes explain: \_\_\_\_\_

Have you received counseling for this issue?  Yes  No If yes, by whom: \_\_\_\_\_

Have you ever been *emotionally* abused?  Yes  No If yes explain: \_\_\_\_\_



Have you received counseling for this issue?  Yes  No If yes, by whom: \_\_\_\_\_

Have you ever been accused of sexually abusing anyone else?  Yes  No If yes, victim(s) (gender, age, family or not, etc.—do not include names) and your age(s) at time(s) of committing abuse(s): \_\_\_\_\_

Was your abuse reported to the authorities?  Yes  No If yes, what was the Outcome? \_\_\_\_\_

Are you required to register as a sex offender?  Yes  No. Indicate Level:  I.  II.  III. (If II or III, do an Offender Contract) If "Yes," is your registration current?  Yes  No List State/County \_\_\_\_\_

(Note to counselor: Obtain releases to County Sheriff where involved, and any other relevant Legal)

**INTERPERSONAL**

Do you have children?  Yes  No Are any of your children not in your care?  Yes  No

If yes explain (including any loss of parental rights): \_\_\_\_\_

What community supports do you have? \_\_\_\_\_

Do you have supportive family members?  Yes  No Supportive friends?  Yes  No

Are you currently in a relationship?  Yes  No Is your Spouse/SO supportive?  Yes  No

Current living situation? \_\_\_\_\_

Who is supportive of you stopping gambling? \_\_\_\_\_

What do you do for fun – leisure activities? \_\_\_\_\_

During the past 12 months have you had any significant relationship problems due to gambling?  Yes  No If yes what? \_\_\_\_\_

On a scale from 1 to 10 with 10 being "I will do whatever to stop gambling" where are you? \_\_\_\_\_

**Educational - Vocational**

Do you have any military history?  Yes  No If yes explain: \_\_\_\_\_

Have you worked in the last 6 months?  Yes  No Primary occupation: \_\_\_\_\_

If yes explain (include job titles and last full time employment): \_\_\_\_\_

Have you ever been wrote up or reprimanded at work due to gambling? ?  Yes  No If yes explain: \_\_\_\_\_

Have you ever stolen from work to support your gambling? ?  Yes  No If yes explain: \_\_\_\_\_

Are you interested in any type of vocational training or continued education?  Yes  No If yes explain: \_\_\_\_\_

**LEGAL**

Have you ever been in trouble with the law?  Yes  No If Yes, was it due to gambling?  Yes  No

Do you have any upcoming court dates?  Yes  No Are you currently on probation?  Yes  No

Are you court ordered to do gambling treatment?  Yes  No If yes, get a signed release of information.



**FINANCIAL**

Estimated debt in dollars as a result of gambling – this includes credit cards, loans from family etc. \$\_\_\_\_\_

Do you have funds for basic needs?  Yes  No Have you ever had any items repossessed?  Yes  No

Are you struggling or feeling stress about your finances?  Yes  No

Do you have credit cards?  Yes  No Are they maxed out?  Yes  No

Do you have a checking account?  Yes  No Do you balance it:  Daily  Weekly  Monthly  Never

Have you ever filed for bankruptcy?  Yes  No

Is finances/budgeting an issue you would like to work on?  Yes  No

**Spiritual**

Do you currently identify with any organized religion?  Yes  No. Or other spiritual beliefs/practices?  Yes  No.

Please explain:

Do you believe in a higher power?  Yes  No

Explain:

Do you believe that what goes around comes around?  Yes  No Explain: