



Gambling Assessment –Family Member

Presenting Problem

How did you hear about our program? _____

Describe what is happening in the gambler’s life that helped you make the decision to inquiry about gambling treatment at this time:

How do they see gambling directly affecting their life? Example: not doing things with family, using household funds to gamble etc?

Has the family member’s gambling impacted anyone else besides you? _____

Gambling History

Overview of gambling history for the family members (first experience, big win, life events, affects on self, family, work, health etc...

Which pattern of gambling most describes your family member?
 _____ Regular gambler-gambles some every month – including those who might be in early remission, have not gabled 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 days episodes.

What ways have they tried in the past to stop gambling? _____

Were any of them helpful? Yes No. If yes which ones? _____

Intrapersonal Issues

Physical Health

How would they describe their health on a scale of 1 to 10? 10 being the Best they ever felt.
 Scale: 1 2 3 4 5 6 7 8 9 10

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

Family member’s nutritional status: # of meals a day _____. Do they eat a balanced diet? Yes No

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

Sleep Patterns: Do they have a regular bedtime and wake up time? Yes No. Sleep _____ hours per night



Do they feel rested when you wake up? Yes No Do they take naps regularly during the day? Yes No
 Do they have any other medical conditions? Yes No If yes what? _____
 Do they have a primary care physician? Yes No If yes – Name _____
 Do they have any limitations that impact daily activities? Yes No If yes what? _____

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

Mental Health or other Emotional Issues

Has there ever had a significant period in which they experienced the following?

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

What is your rating of their mental health? Poor Average Good Excellent
 Do they like themselves? Yes No Explain: _____

Is there anything they did in their past that still bothers you today? No Yes, If yes; Describe: _____

Suicide Ideation/Attempts

Do they have a family history of suicide? Yes No If yes; explain: _____
 Have they ever (past or present) thought about committing suicide? Yes No If yes date of last thought: _____
 Do they have a current plan to harm themselves? 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 Contact must be signed. If risk is above an 8 and client is unable to contract for safety call a CDMHP.

Violence/Abuse History

Do they have homicidal thoughts? Yes No. If yes explain: _____
 Do they have a history of combative or assaultive behavior? Yes No. If yes date of last thought: _____
 Do they have a current plan to harm themselves? Yes No If yes evaluate level of risk.
 Have they ever been *physically* abused? Yes No If yes explain: _____
 Have they received counseling for this issue? Yes No If yes, by whom: _____
 Have they ever been *sexually* abused? Yes No If yes explain: _____
 Have they received counseling for this issue? Yes No If yes, by whom: _____
 Have they ever been *emotionally* abused? Yes No If yes explain: _____
 Have they received counseling for this issue? Yes No If yes, by whom: _____
 Have they 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 their age(s) at time(s) of committing abuse(s): _____

Was their abuse reported to the authorities? Yes No If yes what was the Outcome? _____
 Are they 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 their registration current? Yes No List State/County: _____
 (Note to counselor: Obtain releases to County Sheriff where involved, and any other relevant Legal)



INTERPERSONAL

Do they have children? Yes No Are any of their children not in your care? Yes No
 If yes explain (including any loss of parental rights): _____
 What community supports do they have? _____
 Do y they have supportive family members? Yes No Supportive friends? Yes No
 Are they currently in a relationship? Yes No Is their Spouse/SO supportive? Yes No
 Current living situations? _____
 Who else is supportive of their stopping gambling? _____
 What do they do for fun – leisure activities? _____
 During the past 12 months have they had any significant relationship problems with their spouse/partners 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 is their spouse/partner? _____

Educational - Vocational

Do they have any military history? Yes No IF yes explain: _____
 Have they worked in the last 6 months? Yes No Primary occupation: _____
 If yes explain (include job titles and last full time employment): _____
 Has the gambler ever been wrote up or reprimanded at work due to gambling? Yes No If yes explain: _____
 Do you suspect that the gambler has committed illegal acts to support their gambling? Yes No If yes explain: _____

LEGAL

Has their partner/spouse ever been in trouble with the law? Yes No If Yes, was it due to gambling? Yes No
 Do they have any upcoming court dates? Yes No Are they currently on probation? Yes No
 Have they been court ordered to participate in gambling treatment? Yes No If yes explain: _____

FINANCIAL

Estimated debt in dollars as a result of gambling – this includes credit cards, loans from family etc. \$ _____
 Do they have funds for basic needs? Yes No Have they ever had any items repossessed? Yes No
 Are they struggling or feeling stress about their finances? Yes No
 Do they have credit cards? Yes No Are they maxed out? Yes No
 Do they have a checking account? Yes No Do they balance it: Daily Weekly Monthly Never
 Have they ever filed for bankruptcy? Yes No

SPIRITUAL

Do they currently identify with any organized religion? Yes No. Or other spiritual beliefs/practices? Yes No
 Please explain: _____
 Do they believe in a higher power? Yes No
 Explain: _____
 Do they believe that what goes around comes around? Yes No
 Explain: _____