



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:



NO SELF-HARM CONTRACT

I, _____, commit with ECAR Evaluation and Counseling Services to use the following skills if I feel at risk of harming myself in any way.

___ **1. Use Distraction Skills:**

Count to 10, Count Colors, Read, Watch TV, Observe & Describe Skill, Diaphragmatic Breathing, Watch a Funny Movie, Hold Ice in Your Hand, Exercise, Take a Walk, Listen to Music, Drink Tea, Stand Under a Hot/ Cold Shower, Color, Stretch, Take a Mental Time Out, Clean the House, etc.

___ **2. Use Self-Soothe Skills:**

Encourage Yourself, Positive Self-Affirmations, Repeat, "I can stand it. It won't last forever. I will make it out of this. I'm doing the best I can do". Take a Bubble Bath. Light Candles. Positive Thinking.

___ **3. Call a Friend,** _____, **phone:** _____

___ **4. Call Sponsor,** _____, **phone:** _____

___ **5. Call my Mental Health Therapist:** _____, **phone:** _____.

___ **6. Call my ECAR counselor,** _____, **phone:** _____.

___ **7. Call the King County Crisis Hotline 1 866 427 4747 24-hours-A-Day, 7-days a Week**

___ **8. Call 911**

___ **9. Go To the Emergency Department**

___ **10. Other special conditions:** _____

Client's Signature Date

Counselor's Signature Date



NODS

	Please mark YES or NO for each question with an 'X' (please leave the score column blank)	YES	NO	score
1	In the past year have there been periods lasting two weeks or longer when you spent a lot of time thinking about your gambling experiences or planning out future gambling ventures or bets?	YES	NO	
2	In the past year have there been periods lasting two weeks or longer when you spent a lot of time thinking about ways of getting money to gamble with?	YES	NO	
3	In the past year have there been periods when you needed to gamble with increasing amounts of money or with larger bets than before in order to get the same feeling of excitement?	YES	NO	
4	In the past year have you tried to stop, cut down, or control your gambling?	YES	NO	
5	On one or more of the times when you tried to stop, cut down, or control your gambling, were you restless or irritable?	YES	NO	
6	Since last year have you tried <i>but not succeeded</i> in stopping, cutting down or controlling your gambling?	YES	NO	
7	In the past year has this happened three or more times?	YES	NO	
8	In the past year have you gambled as a way to escape from personal problems?	YES	NO	
9	In the past year have you gambled to relieve uncomfortable feelings such as guilt, anxiety, helplessness or depression?	YES	NO	
10	In the past year has there been a period when, if you lost money gambling one day, you would return another day to get even?	YES	NO	
11	In the past year have you more than once lied to family members, friends or others about how much you gamble or how much money you lost on gambling?	YES	NO	
12	Since Last year have you written a bad check or taken money that didn't belong to you from family member or anyone else in order to pay for you gambling?	YES	NO	
13	Has this happened more than once?	YES	NO	
14	In the past year has your gambling caused serious or repeated problems in your relationships with any of your family members or friends?	YES	NO	
15	In the past year has your gambling caused you any problems in school, such as missing classes or days of school or getting worse grades?	YES	NO	
16	In the past year has your gambling caused you to lose a job, have trouble with your job or miss out on an important job or career opportunity?	YES	NO	
17	In the past year have you needed to ask family members or anyone else to loan you money or otherwise bail you out of a desperate money situation that was largely caused by your gambling?	YES	NO	

To score: Add one point for every “yes” to the following items: 3, 5, 7, 10, 12, 13, and 17

1 or 2 – 1 point

8 or 9 – 1 point

14 or 15 or 16 – 1 point