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?

☐ 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 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:_____