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

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 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

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