DDAP-EFM-1302 Rev. 7-25

Pennsylvania Department of Drug and Alcohol Programs

GAMBLING TREATMENT PROGRAM
Gambling Screening Tool

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Type of Screening: ☐ Telephone ☐ In-Person ☐ Telehealth Video **Date:** _____

Preferred Language: English ☐ Other _____ **Would you like an interpreter?** ☐ Yes ☐ No

DEMOGRAPHICS

Name: _____ **Date of Birth:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone: _____

Referral Source: _____

Gender: ☐ Man ☐ Woman ☐ Other _____ **Spiritual/ Religious Preference:** _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow/Widower

DRUG & ALCOHOL

☐ Yes ☐ No Are you currently using drugs or alcohol? Last Use: _____

What are you currently using (alcohol/drug?)

How much/often are you drinking/using? _____

☐ Yes ☐ No Are you experiencing any of the following withdrawal symptoms?

☐ Uncontrollable Shaking ☐ Hallucinations ☐ Seizures ☐ Nausea/Vomiting ☐ Severe Cramps

☐ Other _____

☐ Yes ☐ No Have you *ever* experienced any of the above symptoms? If so, explain:

☐ Yes ☐ No Have you ever received drug/alcohol treatment or services? If yes, most recent?

Type: ☐ Inpatient Non-Hospital ☐ Inpatient Hospital ☐ Intensive Outpatient ☐ Outpatient ☐ Partial Hospitalization

Other *(Specify)*: _____

PSYCHIATRIC

☐ Yes ☐ No Are you having any thoughts of harming yourself or others? (If yes, he/she must be transferred to a clinical staff person.)

Suicide Plan:

Ability to contract for safety:

Thoughts to harm others:

Plan to harm others:

☐ Yes ☐ No Have you ever received mental health services? If Yes, most recent: _____

Type: ☐ Inpatient ☐ Outpatient ☐ Other *(Specify)*: _____

☐ Yes ☐ No Was medication prescribed? If Yes, specify: _____

GAMBLING

Type(s) of Gambling Engaged In *(Check all that apply)*

- ☐ None *(Significant Other Only)*
- ☐ Bingo
- ☐ Cards
- ☐ Dice Games
- ☐ Dogs/ Other Animals
- ☐ Fantasy Sports
- ☐ Skill Machines
- ☐ Horses
- ☐ iLottery
- ☐ Lottery
- ☐ Office Pools/ Raffles
- ☐ Online/ Internet
- ☐ Roulette
- ☐ Slot Machines
- ☐ Sports Betting
- ☐ Stock/Commodities
- ☐ Video Game Terminals (VGT)
- ☐ Video Gaming
- ☐ Video Lottery Terminal (VLT)

Gambling Location(s) during the last 12 months *(Check all that apply)*

- ☐ None *(Significant Other Only)*
- ☐ Airport
- ☐ Bookie
- ☐ Casino
- ☐ Church/Community/ Senior Ctr
- ☐ Club/Bar/Restaurant
- ☐ Fire Hall
- ☐ Grocery/ Convenience Store
- ☐ Home
- ☐ Lottery Retailer
- ☐ Off Track Betting (OTB)
- ☐ Race Track
- ☐ School
- ☐ Truck Stop/ Gas station
- ☐ Work

During the past 30 days, what amount of money did you spend on a typical day of gambling? $ _____

During the past 30 days, how much time did you usually spend on a typical day of gambling? _____ Hours _____ Mins.

During the past 30 days, on how many days did you gamble? _____ Days

EMPLOYMENT/FUNDING/LEGAL

☐ Yes ☐ No Are you employed? Employer: _____

☐ Yes ☐ No Do you have health insurance or Medical Assistance? *(Specify):* _____

☐ Yes ☐ No Have you ever served in the military?

☐ Yes ☐ No Other funding sources? (Specify): _____

☐ Yes ☐ No Are you involved with the criminal/juvenile justice system?

If yes, what is your status? _____

☐ Yes ☐ No Do you have any pending charges?

If yes, specify: _____

☐ Yes ☐ No Are you currently on probation?

REFERRAL FOR EMERGENT CARE SERVICES

**** SCREENER****

☐ Yes ☐ No Is there a need for a referral for emergent care services to another provider?

Reason:

If Yes, where?

SIGNATURE IS REQUIRED ON THIS FORM:

Screener's Printed Name: _____

Screener's Signature: _____

Screener's Title: _____

Date: _____