DDAP-EFM-1323 Rev. 6/26

Pennsylvania
Department of Drug and Alcohol Programs

Problem Gambling Case Management Client Assessment Form

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Client ID: _____ Interviewer Name: _____

Interview Date: _____

Initial Contact Date: _____

Initial Contact type: ☐ Phone ☐ Referral ☐ Walk-In **Intake Date:** _____

CLIENT PROFILE

First Name: _____ Last Name: _____

DOB: _____

How Long at Current Address? _____ Years _____ Months

Is the Residence Owned by You or Family? ☐ Yes ☐ No

Controlled Environment in Last 30 Days? ☐ No ☐ Jail ☐ Drug Tx ☐ Medical Tx ☐ Psychiatric Tx

☐ Gambling Tx ☐ Other _____

How Many Days in Controlled Environment?_____

Primary Payment Source

☐ Self-Pay ☐ Private Insurance ☐ Medicaid ☐ Other Government Payments

☐ Other Health Insurance Companies ☐ DDAP Gambling Funds ☐ No Charge (Free, Charity, Special Research or Teaching) ☐ Other_____

PROBLEM GAMBLING HISTORY

1. Is the client the identified person with a gambling problem?
   ☐ Yes, proceed to next question ☐ No, proceed to question 3
2. What is the longest number of days in a row that you have gone without gambling:
   a. In the last 30 days? _____
   b. In the last 6 months? _____
3. How many times in the last 30 days have you gambled?
   ☐ More than 3 times daily ☐ 2-3 times daily ☐ Daily ☐ 3-6 times per week
   ☐ 1-2 times per week ☐ 1-3 times per month ☐ No use in past month ☐ Unknown
4. How many times in your life have you received services for Problem Gambling? _____
5. How many days in the last 30 have you received services for Problem Gambling Outpatient Treatment?___
6. How many days in the last 30 have you received services for Problem Gambling Case Management?_____
7. How many times in the last 30 days have you attended GA/GAM-ANON/Other Recovery Groups?_____

Interviewer Rating:

How would you rate the client's need for problem gambling case management services?

☐ Critical ☐ High ☐ Moderate ☐ Low ☐ Not at all

Notes:_____

_____

_____

FINANCIAL ASSESSMENT

1. When you get paid, how do you typically spend your money?_____

   _____

2. How do you decide what gets paid or purchased first? _____

   _____

3. Do you have any non-gambling related debt (i.e. school loan, etc.)? ☐ Yes ☐ No
   If yes, please describe in detail the amount, who you owe, and origin of the debt:_____

   _____

4. Do you have any gambling-related debt? ☐ Yes ☐ No If yes, please describe in detail the amount, who you owe, and origin of the debt: _____

   _____

5. Do you receive online billing notifications through a separate email account that loved ones do not know about? ☐ Yes ☐ No

6. Have you recently opened a separate bank account due to gambling issues? ☐ Yes ☐ No

7. Have you removed a joint account holder's name from a bank account due to gambling activities ☐ Yes ☐ No

8. Have you ever filed for bankruptcy, needed debt consolidation (all debts into one loan), or needed debt restructuring (modifying the terms of current debts)? ☐ Yes ☐ No If yes, please describe:_____

   _____

9. How has gambling or gambling of your loved one impacted you emotionally? _____

   _____

CASE MANAGEMENT NEEDS

1. Do you need assistance in any of these areas ?

Childcare (i.e. childcare access; infant supplies; childcare costs; custody/visitation, etc.)	☐ Yes	☐ No
Clothing (i.e. obtaining clothing items for self and dependents through Missions, etc.)	☐ Yes	☐ No
Digital Access (i.e. access to smart phone, cell phone, cell phones for soldiers/veterans; computer or tablet, internet access for health/employment information)	☐ Yes	☐ No
Employment (i.e. job search, resume writing; CareerLink referral; OVR, etc.)	☐ Yes	☐ No
Family Assistance (i.e. counseling, resources, education-GED, etc.)	☐ Yes	☐ No
Financial and/or Credit Counseling (i.e. financial resource strain, income not covering living costs, budgeting, asset protection)	☐ Yes	☐ No
Food Insecurity (i.e. local food bank, missions, food assistance)	☐ Yes	☐ No
Housing (i.e. housing stability, emergency shelter, housing assistance, VA home)	☐ Yes	☐ No
Legal Assistance (i.e. referral for legal assistance, coordination with probation/parole, Day Reporting Center, Treatment Court, Veterans Court)	☐ Yes	☐ No
Life Skills (i.e. cleaning, grooming, grocery shopping, cooking, daily living assistance)	☐ Yes	☐ No
Mental Health Services (i.e. referral for evaluation for therapy, medication management)	☐ Yes	☐ No
Physical Health (i.e. applying for insurance, locating a PCP, medication management, medical needs, dental needs, vision and hearing needs, pregnancy testing, establish digital access to health information, prenatal/postpartum care, TB/Hepatitis/HIV testing & treatment)	☐ Yes	☐ No
Safety (i.e. feeling emotionally and physically safe where you live, referral for shelter)	☐ Yes	☐ No
Social & Community Supports (i.e. healthy leisure activities, recovery support groups, social skills)	☐ Yes	☐ No
Substance Use Disorder Services (i.e. referral to SCA or SUD treatment provider)	☐ Yes	☐ No
Transportation (i.e. vehicle needs, bus pass, access to Dr. appointments, employment, meetings, legal appointments)	☐ Yes	☐ No
Utilities (i.e. heat assistance, electricity, water)	☐ Yes	☐ No
Other:_____	☐ Yes	☐ No

2. Have you increased the time spent attempting to recover daily living needs because of your/affected other's gambling? ☐ Yes ☐ No

SUBSTANCE USE HISTORY

1. How many times in your life have you been treated for a Substance Use Disorder? Alcohol?____

Drugs? ____

2. How many times in the last 30 days have you used:

Alcohol? ☐ More than 3 times daily ☐ 2-3 times daily ☐ Daily ☐ 3-6 times per week
☐ 1-2 times per week ☐ 1-3 times per month ☐ No use in past month
☐ Unknown ☐ N/A

Drugs? ☐ More than 3 times daily ☐ 2-3 times daily ☐ Daily ☐ 3-6 times per week
☐ 1-2 times per week ☐ 1-3 times per month ☐ No use in past month
☐ Unknown ☐ N/A

3. How many days in the last 30 have you experienced:

a. Alcohol problems? ____ b. Drug problems? _____

4. How many times have you had:

a. Alcohol DTs?_____ b. A drug overdose? _____

Interviewer Rating:

How would you rate the client's need for alcohol or drug treatment?

☐ Critcal ☐ High ☐ Moderate ☐ Low ☐ Not at all

Notes:_____

_____

_____

NICOTINE USE HISTORY

1. What kind of nicotine do you currently use? ☐ None ☐ Cigarettes ☐ Cigars ☐ Chewing Tobacco ☐ Pipe ☐ E-cigarettes/Vape ☐ Snuff ☐ Unknown ☐ Other (specify)_____

2. If cigarettes, indicate daily amount: ☐ Less than ½ pack ☐ ½ to 1 pack ☐ 1 to 2 packs ☐ More than 2 packs ☐ Unknown

3. If E-cigarettes/Vape, indicate number of pods used daily:_____

4. If Chewing Tobacco or Snuff, indicate number of cannisters used daily:_____

MEDICAL

1. How many times in your life have you been hospitalized for medical treatment? _____

2. How long ago was your last hospitalization for a physical problem? Years_____ Months _____

3. Are you currently experiencing any medical issues? ☐ Yes ☐ No ☐ N/A If yes, please specify: _____

_____

4. Are there any medical conditions that you feel could interfere with participating in case management services? ☐ Yes ☐ No ☐ N/A If yes, please specify: _____

_____

5. Have you noticed an increase in risk-taking behaviors that you contribute to a terminal diagnosis?
☐ Yes ☐ No ☐ N/A

If yes, please specify:_____

6. Are you taking any prescribed medication on a regular basis for a physical problem? ☐ Yes ☐ No

If yes, please list:_____

7. Have you noticed any increased risk-taking behaviors since starting a new medication? ☐ Yes ☐ No

If yes, please list:_____

8. How many days in the last 30 have you experienced medical problems? _____

9. How troubled have you been in the last 30 days by these medical problems?

☐ Not at all ☐ Slightly ☐ Moderately ☐ Considerably ☐ Extremely

10. How many times in the last 30 days have you visited an ER? _____

Interviewer Rating:

How would you rate the client's need for medical treatment?

☐ Critical ☐ High ☐ Moderate ☐ Low ☐ Not at all

Notes:_____

_____

_____

MENTAL HEALTH

Have you had a significant period in the past 30 days or lifetime in which you have:

(*The questions require a Yes/No response for both columns.*)	Past 30 Days	Lifetime
Experienced serious depression, sadness, hopelessness, lack of interest?	☐ Yes ☐ No	☐ Yes ☐ No
Experienced serious anxiety, tension, inability to relax, unreasonable worry?	☐ Yes ☐ No	☐ Yes ☐ No
Experienced hallucinations or saw/heard things that did not exist?	☐ Yes ☐ No	☐ Yes ☐ No
Experienced trouble understanding, concentrating, remembering?	☐ Yes ☐ No	☐ Yes ☐ No
Experienced trouble controlling violent behavior including rage or violence?	☐ Yes ☐ No	☐ Yes ☐ No
Experienced serious thoughts of suicide?	☐ Yes ☐ No	☐ Yes ☐ No
Attempted suicide?	☐ Yes ☐ No	☐ Yes ☐ No
Been prescribed medications for psychological or emotional problems? Please list: _____ _____ _____	☐ Yes ☐ No	☐ Yes ☐ No

1. Have any of these resulted in treatment in a hospital or in-patient setting? ☐ Yes ☐ No ☐ N/A

2. Are you currently receiving any mental health treatment? ☐ Yes ☐ No ☐ N/A

3. How troubled have you been in the last 30 days by these emotional problems?

☐ Not at all ☐ Slightly ☐ Moderately ☐ Considerably ☐ Extremely

4. Do you have significant problems with other addictions such as sex, shopping, or eating disorders?

☐ Yes ☐ No ☐ N/A If yes, please explain:_____

Interviewer Rating:

At the time of the interview was the client:

☐ Yes ☐ No Withdrawn/depressed
☐ Yes ☐ No Hostile
☐ Yes ☐ No Anxious/nervous
☐ Yes ☐ No Having trouble with reality testing, thought disorders, paranoid thinking
☐ Yes ☐ No Having trouble comprehending, concentrating, remembering
☐ Yes ☐ No Having suicidal thoughts

How would you rate the client's need for treatment for emotional problems?

☐ Critical ☐ High ☐ Moderate ☐ Low ☐ Not at all

Notes:_____

_____

_____

EMPLOYMENT

1. Education: ☐ Unknown ☐ None ☐ Some School For grades 1-11, enter the number_____
   ☐ High School Diploma ☐ GED ☐ Some College ☐ Associate Degree ☐ Bachelor Degree
   ☐ Graduate Degree
2. Training or Technical education? Yrs._____ Mo._____
3. Do you have a profession, trade, or skill? ☐ Yes ☐ No
   If yes, please specify:_____
4. Do you have a valid driver's license? ☐ Yes ☐ No
5. Do you have a vehicle available for use? ☐ Yes ☐ No
6. Longest full-time job? Years_____ Months_____
7. Usual or last occupation?
   ☐ Skilled Trade ☐ Service/Support ☐ Sales/Marketing ☐ Creative/Arts
   ☐ Managerial/Administrative ☐ Professional/Technical ☐ None
8. Does someone contribute to your support in any way? ☐ Yes ☐ No
9. Does this constitute the majority of your support? ☐ Yes ☐ No
10. Employment Status:
    ☐ Full-time - Annual Salary: ☐ 0-$19,999 ☐ $20,000-$44,999 ☐ $45,000–$139,999 ☐ $140,000 +

☐ Part-time ☐ Not in Labor Force ☐ Homemaker ☐ Student ☐ Retired ☐ Disabled
☐ Resident of Institution ☐ Other ☐ Unknown Employer:_____

11. How many days in the last 30 were you paid for work? (Include "under the table") _____
12. What is your primary source of income? ☐ Wages/Salary ☐ Public Assistance
☐ Retirement/Pension ☐ Disability ☐ Other ☐ None ☐ Unknown
13. Other Income Sources: ☐ Disability ☐ None ☐ Other ☐ Public Assistance ☐ Retirement/Pension
☐ Unknown ☐ Wages/Salary
14. How many days in the last 30 have you experienced employment problems? ____
15. How many months have you been employed during the last 6 months? _____
16. Do you have current health insurance? ☐ Private Insurance _____

☐ Blue Cross/Blue Shield ☐ Medicare ☐ Medicaid ☐ HMO ☐ Health Choices ☐ SCA

☐ Other_____ ☐ None ☐ Unknown

17. If yes, does it cover problem gambling disorder treatment or problem gambling case management services?
Problem Gambling Treatment ☐ Yes ☐ No Problem Gambling Case Management ☐ Yes ☐ No

Interviewer Rating:

How would you rate the client's need for employment services?

☐ Critical ☐ High ☐ Moderate ☐ Low ☐ Not at all

FAMILY/SOCIAL RELATIONSHIPS

1. What is your current relationship status?
☐ Unknown ☐ Never Married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
2. Are you satisfied with this situation? ☐ Yes ☐ No ☐ Indifferent
If no, please describe:_____
3. Are you satisfied with your living arrangements? ☐ Yes ☐ No ☐ Indifferent
4. Do you live with anyone who:
   a. Exhibits problematic gambling behaviors? ☐ Yes ☐ No
   b. Exhibits alcohol misuse? ☐ Yes ☐ No
   c. Exhibits prescription or non-prescription drug misuse? ☐ Yes ☐ No
5. With whom do you spend most of your free time? ☐ Alone ☐ Family ☐ Friends
6. Are you satisfied spending your free time this way? ☐ Yes ☐ No ☐ Indifferent
7. Do you have any family, friend group or cultural traditions of gambling together? ☐ Yes ☐ No
If yes, please describe:_____
8. How many close friends do you have?_____

9. What are some common activities you engage in with your family or friends?_____

_____

10. Select the people with whom you have had a close, long-lasting relationship:
☐ Brother/Sister ☐ Children ☐ Father ☐ Mother ☐ Friends ☐ Grandparent(s) ☐ Aunt(s)
☐ Uncle(s) ☐ Other_____

11. Have you had significant periods in the last 30 days or in your lifetime in which you have experienced serious problems getting along with your:

(***Yes/No response is required for both columns.***)

	Past 30 Days	**Lifetime**
Mother	☐ Yes ☐ No	☐ Yes ☐ No
Father	☐ Yes ☐ No	☐ Yes ☐ No
Brother/sister	☐ Yes ☐ No	☐ Yes ☐ No
Sexual partner/Spouse	☐ Yes ☐ No	☐ Yes ☐ No
Children	☐ Yes ☐ No	☐ Yes ☐ No
Other Significant Family	☐ Yes ☐ No	☐ Yes ☐ No
Close friends	☐ Yes ☐ No	☐ Yes ☐ No
Neighbors	☐ Yes ☐ No	☐ Yes ☐ No
Co-workers	☐ Yes ☐ No	☐ Yes ☐ No

12. Do you have any abuse history either currently or in the past with the people listed below? If so, how and when?

(***Yes/No response is required for all columns***)

Person	**Past 30 Days**			**Lifetime**		
	Emotionally	**Physically**	**Sexually**	**Emotionally**	**Physically**	**Sexually**
Mother	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Father	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Brother/sister	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Sexual Partner/ Spouse	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Children	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Other Significant Family	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Close friend	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Neighbor	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Co-worker	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N

13. How many children do you have that are age 17 or less (birth, adopted, or stepchildren) whether they live with you or not? _____ How many of these children spent the last 6 months living with you? _____

14. Are any of your children living with someone else because of a child protection order? ☐ Yes ☐ No

15. Does your problematic gambling or the gambling of an affected other cause problems at home with your partner, kids, or home obligations? ☐ Yes ☐ No

16. Do you have a Children and Youth Services (CYS) Caseworker? ☐ Yes ☐ No

17. How troubled have you been in the last 30 days by:

a. Family problems? ☐ Not at all ☐ Slightly ☐ Moderately ☐ Considerably ☐ Extremely

b. Social problems? ☐ Not at all ☐ Slightly ☐ Moderately ☐ Considerably ☐ Extremely

18. Have you given up or reduced your involvement in important social or recreational activities that did NOT include gambling, drinking, or using drugs? ☐ Yes ☐ No

19. Is there a family history of substance abuse or dependency? ☐ Yes ☐ No

20. Is there a family history of problematic gambling? ☐ Yes ☐ No

Interviewer Rating:

How would you rate the client's need for family or social counseling?

☐ Critical ☐ High ☐ Moderate ☐ Low ☐ Not at all

Notes:_____

_____

_____

LEGAL

1. Was this admission prompted by the criminal justice system? ☐ Yes ☐ No

2. Are you on parole or probation? ☐ Yes ☐ No

3. Have you ever been arrested and/or criminally charged (i.e. forgery, embezzlement, gambling-related crime, robbery,etc.) ? ☐ Yes ☐ No If yes, please explain

_____

4. How many times have you been arrested in the past 12 months? _____

5. How many times have you been arrested in the past 30 days?_____

6. What is the longest length of time you were incarcerated in your life?
Years_____Months_____Days_____

7. How long was your last incarceration? Years_____ Months_____ Days_____

a. What was it for? _____

8. Are you presently awaiting charges, trial, or sentencing? ☐ Yes ☐ No

a. If yes, what for? _____

9. How many days in the last 30 have you engaged in illegal activities for profit?_____

10. How serious do you feel your current legal problems are?

☐ Not at all ☐ Slightly ☐ Moderately ☐ Considerably ☐ Extremely

Interview Rating:

How would you rate the client's need for legal services?

☐ Critical ☐ High ☐ Moderate ☐ Low ☐ Not at all

Notes:_____

_____

_____

MOTIVATION

1. Is the client motivated to change their gambling behavior? ☐ Yes ☐ No ☐ N/A
2. Is the client motivated to change their alcohol/drug use? ☐ Yes ☐ No ☐ N/A
3. Is the client motivated to change their nicotine use? ☐ Yes ☐ No ☐ N/A
4. How important to the client is treatment for any medical problems?
   ☐ Not at all ☐ Slightly ☐ Moderately ☐ Considerably ☐ Extremely
5. Are there any psychological conditions which interfere with the client's treatment needs? ☐ Yes ☐ No
6. How important to the client is treatment for these psychological problems?
   ☐ Not at all ☐ Slightly ☐ Moderately ☐ Considerably ☐ Extremely

Interview Confidence Rating:

How would you rate the client's readiness to change?

☐ Action ☐ Contemplation ☐ Determination ☐ Maintenance ☐ Pre-contemplation ☐ Relapsed

SUMMARY

Interviewer Confidence Rating:

1. In your opinion, is the information in this assessment significantly distorted due to the client's misrepresentation?
   ☐ Not at all ☐ Slightly ☐ Moderately ☐ Considerably ☐ Extremely
2. In your opinion, is the information in this assessment significantly distorted due to the client's ability to understand? ☐ Not at all ☐ Slightly ☐ Moderately ☐ Considerably ☐ Extremely

Comments:_____

_____

_____

MISCELLANEOUS NOTES

Summary:_____

_____

_____

_____

Assessment Duration

Interview: Start Date/ Time:_____ End Date/ Time:_____ Total Interview Time:_____