



Problem Gambling Outpatient Treatment Client Assessment Form

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 Outpatient Treatment services?

Critical

High

Moderate

Low

Not at all

Notes: _____

CASE MANAGEMENT NEEDS

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

Childcare

Clothing

Digital Access (phone, computer)

Employment

Family Assistance

Financial and/or Credit Counseling

Food Insecurity

Housing

Legal Assistance

Life Skills

Mental Health Services

Physical Health

Safety (in your home)

Social/Community Supports

Substance Use Disorder Services

Transportation

Utilities

Others _____

N/A

If yes to any need, a referral should be made for problem gambling case management services.

Notes: _____

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?

Critical 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:

<i>(The questions require a Yes/No response for both columns.)</i>	Past 30 Days		Lifetime	
	Yes	No	Yes	No
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	
	Yes	No	Yes	No
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: _____