

ID: _____	Last name: _____	First name: _____	Date: ____/____/20____
Age: _____	Race/ethnicity: White <sup>0</sup> African American <sup>1</sup> Hispanic <sup>2</sup> Asian <sup>3</sup> Native American <sup>4</sup> Other <sup>5</sup>		
Gender: M <sup>0</sup> F <sup>1</sup> Transgender <sup>2</sup> Gender neutral <sup>3</sup>		Location: _____	Clinician: _____
Circle <u>ONE</u> referral source: Readmission <sup>0</sup> GA/Gamanon <sup>1</sup> Helpline <sup>2</sup> Internet <sup>3</sup> Gambling research program <sup>4</sup>			
MH residential <sup>5</sup> : _____		MH outpatient <sup>6</sup> : _____	Bettor choice <sup>7</sup> : _____
SA residential <sup>8</sup> : _____		SA outpatient <sup>9</sup> : _____	EAP <sup>10</sup> : _____
Private therapist <sup>11</sup> : _____		Probation <sup>12</sup> : _____	Attorney <sup>13</sup> : _____
Hospital/medical <sup>14</sup> : _____		Advertisement <sup>15</sup> : _____	Other <sup>16</sup> : _____

### MEDICAL STATUS

1. How many days have you experienced medical problems in the past 30 days? \_\_\_\_\_ days
2. How troubled or bothered have you been by these medical problems in the past 30 days?  
Not at all<sup>0</sup>      Slightly<sup>1</sup>      Moderately<sup>2</sup>      Considerably<sup>3</sup>      Extremely<sup>4</sup>
3. How important to you now is treatment for these medical problems?  
Not at all<sup>0</sup>      Slightly<sup>1</sup>      Moderately<sup>2</sup>      Considerably<sup>3</sup>      Extremely<sup>4</sup>

### GAMBLING INFORMATION

1. Who is the **person with a gambling issue** you are concerned about?
  - child
  - parent
  - spouse/partner
  - sibling
  - other (friend, co-worker, etc.)
2. What do you think the gambling **debt** might be?      \$ \_\_\_\_\_
3. **When** did you become aware of the gambling of your loved one?
4. **When** did you become aware that gambling was a problem?
5. What is the **primary form** of gambling for your loved one? Circle **one** only.  
Lottery<sup>1</sup>   Scratch<sup>2</sup>   Keno<sup>3</sup>   Slots<sup>4</sup>   Cards<sup>5</sup>   Sports<sup>6</sup>   Dice<sup>7</sup>   Internet<sup>8</sup>   Other<sup>9</sup>: \_\_\_\_\_
6. What other forms of gambling may be problematic for your loved one? Circle **all** that apply.  
None<sup>4a</sup>   Lottery<sup>4b</sup>   Scratch<sup>4c</sup>   Keno<sup>4d</sup>   Slots<sup>4e</sup>   Cards<sup>4f</sup>   Sports<sup>4g</sup>   Dice<sup>4h</sup>   Internet<sup>4i</sup>   Other<sup>4j</sup>: \_\_\_\_\_
7. Have you ever received **gambling-related treatment** before?      No<sup>0</sup>    Yes, here<sup>1</sup>    Yes, but only at another program<sup>2</sup>
8. How many times have you been to **Gam-Anon** meetings?  
None<sup>0</sup>      Once<sup>1</sup>      2-10 times<sup>2</sup>      More than 10 times<sup>2</sup>
9. Have you **ever filed for bankruptcy** because of gambling related problems?  
No, and I don't plan to<sup>0</sup>      No, but I am thinking about it<sup>1</sup>      Yes, I filed for bankruptcy<sup>2</sup>
10. How many **days did you gamble** in the past 30 days?  
*Include days you made any bets at all, even just buying a lottery ticket?*      \_\_\_\_\_ days
11. How **much did you gamble in total** during the past 30 days?  
*(Include all money or items risked on all forms of gambling)*      \$ \_\_\_\_\_

12. How many days have you **experienced problems** related to your loved one's gambling in the past 30 days?  
 \_\_\_\_\_ days

13. How **troubled or bothered** have you been in the past 30 days by your loved one's gambling?  
 Not at all<sup>0</sup>      Slightly<sup>1</sup>      Moderately<sup>2</sup>      Considerably<sup>3</sup>      Extremely<sup>4</sup>

14. How **important to you now is treatment**?  
 Not at all<sup>0</sup>      Slightly<sup>1</sup>      Moderately<sup>2</sup>      Considerably<sup>3</sup>      Extremely<sup>4</sup>

**FAMILY AND SOCIAL RELATIONSHIPS**

1. Relationship Issues:      Yes<sup>0</sup>      No<sup>1</sup>

If yes, check all that apply:

Conflict<sup>0</sup>      Violence<sup>1</sup>      Neglect<sup>2</sup>

2. Emotional impact on you as the concerned person:

- Depression<sup>0</sup>
- Anxiety<sup>1</sup>
- Anger<sup>2</sup>
- Sleep problems<sup>3</sup>
- Decreased work/school performance<sup>4</sup>
- Suicidal thoughts<sup>5</sup>
- Suicide intent or attempts<sup>6</sup>
- Other: \_\_\_\_\_<sup>7</sup>

3. Emotional impact on other family members:

- Depression<sup>0</sup>
- Anxiety<sup>1</sup>
- Anger<sup>2</sup>
- Sleep problems<sup>3</sup>
- Decreased work/school performance<sup>4</sup>
- Suicidal thoughts<sup>5</sup>
- Suicide intent or attempts<sup>6</sup>
- Other: \_\_\_\_\_<sup>7</sup>

4. Emotional impact on the gambler:

- Depression<sup>0</sup>
- Anxiety<sup>1</sup>
- Anger<sup>2</sup>
- Sleep problems<sup>3</sup>
- Decreased work/school performance<sup>4</sup>
- Suicidal thoughts<sup>5</sup>
- Suicide intent or attempts<sup>6</sup>
- Other: \_\_\_\_\_<sup>7</sup>

5. How troubled or bothered have you been in the past 30 days by family problems?

Not at all<sup>0</sup>      Slightly<sup>1</sup>      Moderately<sup>2</sup>      Considerably<sup>3</sup>      Extremely<sup>4</sup>

6. How important to you now is treatment or counseling for family problems?

Not at all<sup>0</sup>      Slightly<sup>1</sup>      Moderately<sup>2</sup>      Considerably<sup>3</sup>      Extremely<sup>4</sup>

**PSYCHIATRIC STATUS**

0a. Have you ever attempted suicide in your lifetime? No<sup>0</sup> Yes<sup>1</sup> 0b.If yes, year of most recent attempt: \_\_\_\_\_

In the past 30 days, have you had significant periods (not directly related to substance use), in which you:

- 1. Experienced serious depression NO<sup>0</sup> YES<sup>1</sup>
- 2. Experienced serious anxiety or tension NO<sup>0</sup> YES<sup>1</sup>
- 3. Experienced hallucinations NO<sup>0</sup> YES<sup>1</sup>
- 4. Experienced trouble understanding, concentrating or remembering NO<sup>0</sup> YES<sup>1</sup>
- 5. Experienced trouble controlling violent behavior NO<sup>0</sup> YES<sup>1</sup>
- 6. Experienced serious thoughts of suicide NO<sup>0</sup> YES<sup>1</sup>
- 7. Attempted suicide NO<sup>0</sup> YES<sup>1</sup>
  
- 8. In the past 30 days, have you taken prescribed medication for a psychological/emotional problem? No<sup>0</sup> Yes<sup>1</sup>
- 9. How many days in the past 30 have you had psychological or emotional problems? \_\_\_\_\_ days
- 10. In the past 30 days, how troubled or bothered have you been by psychological or emotional problems?  
Not at all<sup>0</sup> Slightly<sup>1</sup> Moderately<sup>2</sup> Considerably<sup>3</sup> Extremely<sup>4</sup>
- 11. How important to you now is treatment for these psychological problems?  
Not at all<sup>0</sup> Slightly<sup>1</sup> Moderately<sup>2</sup> Considerably<sup>3</sup> Extremely<sup>4</sup>

**SUBSTANCE USE**

How many days in the past 30 have you used these substances? *Include use of all non-prescribed substances and prescribed substances that you used more than prescribed.*

- 1. Alcohol: any use at all \_\_\_\_\_ days
- 2. Marijuana \_\_\_\_\_ days
- 3. Benzodiazepines (e.g., valium, librium, xanax) \_\_\_\_\_ days
- 4. Cocaine, methamphetamine, amphetamine \_\_\_\_\_ days
- 5. Heroin \_\_\_\_\_ days
- 6. Other opiates/analgesics (e.g., percocet, oxycodone) \_\_\_\_\_ days
- 7. Any other illicit substance \_\_\_\_\_ days
  
- 8a. How much have you spent during the past 30 days on: alcohol? \$ \_\_\_\_\_
- 8b. drugs? \$ \_\_\_\_\_
  
- 9a. How many days in the past 30 have you experienced: alcohol problems? \_\_\_\_\_ days
- 9b. drug problems? \_\_\_\_\_ days

How troubled or bothered have you been in the past 30 days by:

- 10a. alcohol problems? Not at all<sup>0</sup> Slightly<sup>1</sup> Moderately<sup>2</sup> Considerably<sup>3</sup> Extremely<sup>4</sup>
- 10b. drug problems? Not at all<sup>0</sup> Slightly<sup>1</sup> Moderately<sup>2</sup> Considerably<sup>3</sup> Extremely<sup>4</sup>

How important to you now is treatment for:

- 11a alcohol problems? Not at all<sup>0</sup> Slightly<sup>1</sup> Moderately<sup>2</sup> Considerably<sup>3</sup> Extremely<sup>4</sup>
- 11b. drug problems? Not at all<sup>0</sup> Slightly<sup>1</sup> Moderately<sup>2</sup> Considerably<sup>3</sup> Extremely<sup>4</sup>

**Clinician ratings**

- 1. Did you check that all items are answered? No<sup>0</sup> Yes<sup>1</sup>
- 2. Personal strengths: \_\_\_\_\_
- 3. Cultural strengths: \_\_\_\_\_
- 4. Community resources: \_\_\_\_\_
- 5. Barriers: \_\_\_\_\_
- 6. Did you refer for additional psychiatric services? No<sup>0</sup> Yes<sup>1</sup> 8b.If yes, where: \_\_\_\_\_
- 7. Medical, employment, legal or substance use referral? No<sup>0</sup> Yes<sup>1</sup> 9b. If yes, where: \_\_\_\_\_