

**GAMBLING TREATMENT PROGRAM**
Gambling Screening ToolType of Screening: Telephone Face to Face

Date: _____

DEMOGRAPHICS

Name: _____

Birth/Maiden Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

Referral Source: _____ Phone: _____

Sex: Male Female 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)*

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> None <i>(Significant Other Only)</i> | <input type="checkbox"/> Fantasy Sports | <input type="checkbox"/> Office Pools | <input type="checkbox"/> Stock/Commodities |
| <input type="checkbox"/> Bingo | <input type="checkbox"/> Games of Skill | <input type="checkbox"/> Raffles | <input type="checkbox"/> Video Game Terminals (VGT) |
| <input type="checkbox"/> Cards | <input type="checkbox"/> Horses | <input type="checkbox"/> Roulette | <input type="checkbox"/> Video Gaming |
| <input type="checkbox"/> Dice Games | <input type="checkbox"/> iLottery | <input type="checkbox"/> Slot Machines | <input type="checkbox"/> Video Lottery Terminal (VLT) |
| <input type="checkbox"/> Dogs/ Other Animals | <input type="checkbox"/> Lottery | <input type="checkbox"/> Sports | |

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

- | | | | |
|---|--|--|-------------------------------------|
| <input type="checkbox"/> None <i>(Significant Other Only)</i> | <input type="checkbox"/> Church/Community | <input type="checkbox"/> Home | <input type="checkbox"/> Racino |
| <input type="checkbox"/> Airport | <input type="checkbox"/> Club/Bar/Restaurant | <input type="checkbox"/> Lottery Retailer | <input type="checkbox"/> School |
| <input type="checkbox"/> Bookie | <input type="checkbox"/> Fire Hall | <input type="checkbox"/> Off Track Betting (OTB) | <input type="checkbox"/> Truck Stop |
| <input type="checkbox"/> Casino | <input type="checkbox"/> Grocery | <input type="checkbox"/> Race Track | <input type="checkbox"/> 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 Are you a Veteran? Honorable Discharge? Yes No
- 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?

Screener's Printed Name:

Screener's Signature:

Screener's Title:

Date: