Reno Problem Gambling Center

RPGC Enrollment – Gambling Assistance Program

*The following information that you are asked to provide is **confidential**. Your name will not be released without your written permission. The information requested will help us better understand how we can best assist you. The questions with an asterisk (*) are items required by the funding authority; this allows us to provide subsidized services to you.*

INTAKE

Client Name (First, MI, Last)	***Last 5 digits SSN:**	***DOB:** // //	***Gender:** ☐ M ☐ F ☐ U
1st Contact **1st Available** **Enrollment**		**Client ID**	
Address	**City:**	***County**	
	State:	**ZIP**	
Home Phone	**May we leave messages?** **Home: Yes ☐ No ☐** **Cell: Yes ☐ No ☐**		
Cell Phone	**Email Address**		

***Referral Source:**
☐ Helpline ☐ Family/Friend ☐ Medical/Health Professional ☐ Casino Literature ☐ Media Print ☐ Media Air
☐ Website ☐ Self (returning client) ☐ Former/Other Client ☐ Other:

Why are you seeking services?	***Court Mandated?** ☐ Y ☐ N

***Type of Services requested:**
☐ Outpatient-Gambler (Individual/Group) ☐ Outpatient-Concerned Other ☐ Residential
☐ Crisis Intervention Only ☐ Assessment Only ☐ Consultation Only

DEMOGRAPHIC

***Race/Ethnicity:**
☐ Alaska Native ☐ American Indian ☐ Black/African American ☐ Caucasian/White ☐ Hispanic/Latina/o
☐ Native Hawaiian ☐ Pacific Islander ☐ Other:

***Education/Highest Degree Attained:**
☐ Less than High School ☐ H.S. Diploma/GED ☐ Associates ☐ Bachelors ☐ Masters ☐ Doctorate
☐ Other degree(s):

***Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Living Together

Previous marriages/long-term relationships:

Interpersonal Relationship	**Name**	**Age**	**Occupation**	**How Long?**	**Quality of relationship**

Children	**Name**	**Age**	**Gender**	**Lives with you?**	**Quality of relationship**

What city & state were you born in?	**If not Nevada, when did you move to Nevada?**

***Total Household Income before taxes:**
☐ Less than $10,000 ☐ $10,000-14,999 ☐ $15,000-24,999 ☐ $25,000-34,999 ☐ $35,000-49,999
☐ $50,000-74,999 ☐ $75,000-99,999 ☐ $100,000-149,999 ☐ $150,000-199,999 ☐ $200,000 or more

***Have you served, or are you serving, in the U.S. military?** ☐ Yes (currently) ☐ Yes (previously) ☐ No

VOCATIONAL/EMPLOYMENT

***What is your current Employment Status?**

☐ Employed Full-time ☐ Employed Part-time ☐ Disabled ☐ Retired ☐ Unemployed
☐ Other:

Current Employment: How long? _____ **Hours per Week** _____ **Monthly pay** _____

How do you feel about your current job?_____

LEGAL CONSEQUENCES

***Do you have any current legal issues related to your gambling behavior:** ☐ **Y** ☐ **N (**if yes, check all that apply**)**

☐ Arrest ☐ Outstanding Charges ☐ Jail ☐ Local prison ☐ County prison ☐ State prison ☐ Federal prison
☐ Drug Court ☐ Parole/Probation ☐ Other legal issues:

History of Arrest Charge/Conviction	**Date**

PERSONAL CONSEQUENCES

***What personal loss have you experienced as a result of your gambling? (**check all that apply)

☐ Divorce ☐ Separation ☐ Estrangement from family ☐ Loss of close friends ☐ Loss of romantic relationships
☐ Loss of mental stability ☐ Loss of physical stability ☐ Job loss ☐ Loss of freedom (incarceration)
☐ Other:

PERSONAL ENVIRONMENT

***Which of the following best describe(s) your current living arrangement(s) (check all that apply)**

☐ Living with spouse ☐ Living with partner ☐ Living with your family ☐ Shelter ☐ Homeless
☐ Living with spouse's family ☐ Living with partner's family ☐ Living with friends
☐ Living with spouse's friends ☐ Living with partner's friends ☐ Living alone ☐ Living in a residential facility
☐ Other:

***How many persons under 18 live in your home?**	**Do any of the people you live with gamble?** ☐ **Y** ☐ **N**
Who are the supportive people in your life?	**Who do you want involved in your treatment?**
What type of transportation do you use?	**Do you have a safe and substance free environment?** ☐ **Y** ☐ **N**

PERSONAL VALUES

Parents/Siblings	**Name**	**Age**	**Gender**	**Location**	**Quality of relationship**

GAMBLING HISTORY

***Which of the following gambling games have you played most frequently in the past 12 months?**

☐ Table-Poker ☐ Table-Craps ☐ Table-Roulette ☐ Table-Blackjack ☐ Keno ☐ Slot machines
☐ Video-Poker ☐ Video-Keno ☐ Bingo ☐ Sports book ☐ Online
☐ Other:

***Frequency of primary gambling activity:**

☐ **Once/Twice a month** ☐ **Once/Twice a week** ☐ **3-6 times a week** ☐ **Daily**

***In the past 12 months, on average, how many days a week did you gamble?**

***In the past 12 months, on average, how many hours would you gamble in one episode (i.e., in a single visit)?**

***Which of the following gambling games have you played in the past 12 months?**

☐ Table-Poker ☐ Table-Craps ☐ Table-Roulette ☐ Table-Blackjack ☐ Keno ☐ Slot machines
☐ Video-Poker ☐ Video-Keno ☐ Bingo ☐ Sports book ☐ Online
☐ Other:

***Frequency of secondary gambling activity:**

☐ **Once/Twice a month** ☐ **Once/Twice a week** ☐ **3-6 times a week** ☐ **Daily**

***Not including this evaluation/enrollment, how many times have you started a professional problem gambling treatment program?**

***How many times have you completed a professional problem gambling treatment program?**

***Have you ever attended a Gamblers Anonymous meeting?** ☐ **Y** ☐ **N**

If yes, how many meetings do you estimate you have attended total, and during what years?

How old were you the first time you gambled?	**Who were you with?**	**Where did you gamble?**
How old were you when your gambling became a problem?		
When did you gamble last?	**Where did you gamble last?**	**How much did you spend?**
What was your biggest win?	**When & where?**	
What was your biggest loss?	**When & where?**	

CURRENT FINANCIAL STATUS

List monthly **Income** amounts for household (includes spouse and/or all others who live with you)

Wages	Social Security
SSI Federal	Food Stamps/SNAP
Welfare/Public Assistance	Worker's Comp
Unemployment	Pension/Retirement
Other	**TOTAL**

List monthly **Expenses** for household (includes spouse and/or all others who live with you)

Credit Card Payments	Court-ordered Restitution
Rent and/or Mortgage(s)	Auto Expenses (loans, gas, insurance)
Insurance & Medical Payments	Other loan payments
Alimony and/or Child Support	Food & Utilities
Other	**TOTAL**

***Are you able to meet personal/family financial needs?** ☐ **Y** ☐ **N**

HEALTH STATUS

***In the past 12 months, which substances have you used on more than two occasions?** (check all that apply)

☐ Alcohol ☐ Marijuana ☐ Cocaine ☐ Benzodiazepines ☐ Opiates ☐ Methamphetamines

☐ Prescription drugs ☐ Tobacco/Nicotine ☐ Other drugs/substances: _____

***Over the past 12 months, which have been problematic for you?** (check all that apply)

☐ Alcohol ☐ Marijuana ☐ Cocaine ☐ Benzodiazepines ☐ Opiates ☐ Methamphetamines

☐ Prescription drugs ☐ Tobacco/Nicotine ☐ Other drugs/substances: _____

Have you attended self-help or peer support programs for these problems? ☐ **Y** ☐ **N**

If yes, when/what type? _____

***Over the past 12 months, which have been problematic for you?** (check all that apply)

☐ Shopping ☐ Sex addiction/Pornography ☐ Internet ☐ Eating disorders

☐ Other behavioral issues: _____

Have you attended self-help or peer support programs for these problems? ☐ **Y** ☐ **N**

If yes, when/what type? _____

***Do you have a family history of addiction?**

☐ **Yes, primary relative** (mother/father/sister/brother) ☐ **Yes, other relative** ☐ **No**

***Do you have a family history of problem gambling?**

☐ **Yes, primary relative** (mother/father/sister/brother) ☐ **Yes, other relative** ☐ **No**

***Do you have any disabilities?** ☐ **Y** ☐ **N**

(If yes, check all that apply): ☐ **Physical disability; able to work** ☐ **Physical disability; unable to work**

☐ **Mental disability; able to work** ☐ **Mental disability; unable to work** ☐ **No disabilities**

***Do you have health insurance?** ☐ **Y** ☐ **N**

☐ **HMO** ☐ **PPO** ☐ **Medicare/Medicaid** ☐ **Unsure** ☐ **Other:**

When was your last physical examination?	**Do you have any allergies?** ☐ **Y** ☐ **N** (If yes, list)

Have you had any of the following problems? (Mark all that apply)

☐ High Blood Pressure	☐ Cancer	☐ Seizures
☐ Heart Disease	☐ Backaches	☐ Diabetes
☐ Ringing in the Head	☐ Headaches	☐ Excessive sweats
☐ Loss of Memory	☐ Loss of Balance	☐ Liver/Kidney problems
☐ Numb fingers/toes	☐ Racing heartbeat	☐ Skin infections
☐ Bowel problems	☐ Dizziness	☐ Tuberculosis
☐ Stomach problems	☐ Painful urination	☐ Arthritis
☐ Chronic pain	☐ Impotence	☐ Abnormal pregnancy
☐ Tumors/Cysts	☐ Mental Confusion	☐ Miscarriage

☐ Other

Have you had any serious injuries or overnight hospitalizations? ☐ **Y** ☐ **N**	(If Yes, when, what for, & any residual effects?)
Do you have any medical/dental concerns which are not currently being addressed? ☐ **Y** ☐ **N**	(If Yes, explain)
Have you had a sexually transmitted or communicable disease? ☐ **Y** ☐ **N**	(If Yes, when and are there residual effects)

Medications you are currently taking, including dosage & why:	**Are you taking all medications as prescribed?** ☐ **Y** ☐ **N**

Other medications prescribed for you that you are not currently taking:

Over the counter supplements/medications you are currently taking, why, & are they helping:

PSYCHOLOGICAL HISTORY		
Have you ever been in counseling for something other than a gambling or substance-use problem? ☐ **Y** ☐ **N**	If Yes, when/with whom?	
How was that experience for you?		
Have you recently experienced any of the following emotional states? (Mark all that apply)		
☐ Loneliness	☐ Mood swings	☐ Seeing things that aren't there
☐ Fears or Phobias	☐ Physical fights	☐ Hearing things that aren't there
☐ Anxiety	☐ Recurring Anger	☐ Guilt/Shame
☐ Other		
Are you being medically treated for any of the above? ☐ **Y** ☐ **N**	Medications prescribed:	**Are you currently taking all medications as prescribed?** ☐ **Y** ☐ **N**
Have you or any member of your family experienced mental illness or psychotic episodes? ☐ **Y** ☐ **N**		
Have you previously or are you currently experiencing depression? ☐ **Y** ☐ **N**	If Yes, please explain	
Have you *ever* thought about or threatened to harm yourself? ☐ **Y** ☐ **N**	If Yes, please explain	
Have you *ever* taken action to harm yourself? ☐ **Y** ☐ **N**	If Yes, please explain	
Have you *ever* tried to harm someone else? ☐ **Y** ☐ **N**	If Yes, please explain	
Do you *currently* feel like harming yourself or others? ☐ **Y** ☐ **N**	If Yes, please explain	
PHYSICAL/EMOTIONAL/SEXUAL ABUSE/RAPE		
Please mark any abuse that you have experienced in the past: ☐ **Physical** ☐ **Emotional** ☐ **Sexual** ☐ **Rape** ☐ **Other**		
Please explain		
Please mark any abuse that you are currently experiencing: ☐ **Physical** ☐ **Emotional** ☐ **Sexual** ☐ **Other**		
Please explain		

PERSONAL HABITS		
Do you smoke/chew tobacco? ☐ **Y** ☐ **N**	If Yes, number of packs/cans daily; brand	**Do you want to quit?** ☐ **Y** ☐ **N**
Do you drink more than 4 cups of coffee/soda per day? ☐ **Y** ☐ **N**		**Do you often skip meals?** ☐ **Y** ☐ **N**
Do you consider your dietary habits healthy? ☐ **Y** ☐ **N**		**Do you exercise regularly?** ☐ **Y** ☐ **N**
Are you currently pregnant? ☐ **Y** ☐ **N**		If Yes, how many months pregnant?

PERSONAL VALUES
What are your spiritual/religious interests?
What are your most important values?
What are your strengths and weaknesses?
List some of the major events or achievements you are proud of:
Anything else you think we should know to meet your needs?

DIAGNOSIS & TREATMENT	
DSM-5 score (# criteria) for Gambling Disorder	☐ **Mild** (4-5) ☐ **Moderate** (6-7) ☐ **Severe** (8-9)
☐ **Not in Remission** ☐ **Early** (3-12) ☐ **Sustained** (12+)	☐ **Episodic** ☐ **Persistent**
Preliminary Treatment Plan (Will the client be participating in outpatient or residential treatment?) (check all that apply) ☐ **Outpatient** ☐ **Residential** ☐ **12-Step** ☐ **Other:**	

Does the client consent to the follow-up study? ☐ **Y** ☐ **No**	
Client's Full Name	
Best Contact Number: ☐ **Home** ☐ **Cell**	**Best Contact Number Notes:**
Next Best Number: ☐ **Home** ☐ **Cell**	**Next Best Number Notes:**
Next Best Number: ☐ **Home** ☐ **Cell**	**Next Best Number Notes**

I understand the information provided in these documents will be used to determine my diagnosis and treatment. I will have the opportunity to ask questions of the RPGC staff

"I have had the opportunity to review this form and ask questions of the RPGC staff,"

Signature:_____**Date:** _____