CORRECTED: ☐

GAMBLING CLIENT ENROLLMENT RECORD ABSTRACTING FORM

Leave NO Blank Fields:

UK-Unknown, NA-Does Not Apply, NC-Not Collected, CR-Client Refused

Preferred Language: ___________________

1

Clinic/Provider ID:

Client Case ID:

2

CLIENT NAME: Last First MI

Birth

DOB: MMDDYYYY

Gender:

Ethnicity:

County:

Zip Code:

Access:

Referral:

Mandated:

3

First Contact Date:

First Available Date:

Enrollment Date:

Reason:

4

Education:

Marital Status:

Dependents:

0 - 5

6 – 17

18 – 64

65 +

Housing:

5

Health Insurance:

Employment:

Veteran:

Income Source:

Monthly Household Income:

6

Gambling Debt:

Age 1st Gambled:

Age Onset:

Primary Gambling Activity: Type: ______________ Venue: Jurisdiction:

Secondary Gambling Activity: Type: ______________ Venue: Jurisdiction:

Social Gaming

7

Diagnostic Impression:

Primary: ☐☐ Secondary: ☐☐

Substance Abuse: ☐☐☐☐☐ Specifier: ☐☐

DSM-IV Pathological Gambling:

☐ 1 Preoccupation ☐ 4 Restlessness ☐ 7 Lying ☐ 10 Bailouts

☐ 2 Tolerance ☐ 5 Escape ☐ 8 Committed Illegal Acts for $

☐ 3 Stop/Control ☐ 6 Chasing ☐ 9 Risked Losing Relationships

Suicide:	Job/School Problems:	Bankruptcy:	Relationship Problems:	Legal:
☐☐	☐☐	☐☐	☐☐	☐☐

8

Treatment History:

	Times:	Last Type Treatment	Concurrently Enrolled:	Self Help 12-Step
Gambling:	☐☐	☐☐		☐☐
Alcohol/Drug:	☐☐	☐☐	☐☐	☐☐
Mental Health:	☐☐	☐☐	☐☐	☐☐

9

COMPLETE THIS BOX ONLY WITH RELEASE FOR FOLLOW-UP

Client Primary Contact Information

Mailing Address:

City: State: Zip:

Home Phone:

Release Attached: ☐

10

Primary Counselor:

11

PRINT Completed By: ______________________ Date: ___________ Phone: _______________________