DDAP-EFM-1302 Rev. 7-23

pennsylvania
DEPARTMENT OF DRUG AND ALCOHOL PROGRAMS

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GAMBLING TREATMENT PROGRAM

Gambling Screening Tool

Type of Screening: ☐ Telephone ☐ Face to Face **Date:** ______________________

DEMOGRAPHICS

Name: ____________________________________

Birth/Maiden Name: ____________________________ **Date of Birth:** ________________________

Address: ____

City: ___________________________ **State:** ______ **Zip Code:** ______________________

Phone: ___________________________

Referral Source: ____________________________ **Phone:** ______________________________

Gender: ☐ 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)*

☐ None *(Significant Other Only)* ☐ Fantasy Sports ☐ Office Pools/ Raffles ☐ Stock/Commodities
☐ Bingo ☐ Games of Skill ☐ Online/ Internet ☐ Video Game Terminals (VGT)
☐ Cards ☐ Horses ☐ Roulette ☐ Video Gaming
☐ Dice Games ☐ iLottery ☐ Slot Machines ☐ Video Lottery Terminal (VLT)
☐ Dogs/ Other Animals ☐ Lottery ☐ Sports Betting

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

☐ None *(Significant Other Only)* ☐ Church/Community/ Senior Ctr ☐ Home ☐ School
☐ Airport ☐ Club/Bar/Restaurant ☐ Lottery Retailer ☐ Truck Stop/ Gas station
☐ Bookie ☐ Fire Hall ☐ Off Track Betting (OTB) ☐ Work
☐ Casino ☐ Grocery/ Convenience Store ☐ Race Track

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 Have you ever served in the military?

☐ 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?

SIGNATURE IS REQUIRED ON THIS FORM

Screener's Printed Name: ______________________ Screener's Signature: ______________________

Screener's Title: ______________________ Date: ______________________