

SAT - Problem Gambler Self Assessment Tool

Today's Date: _____

Please place an "X" in the box that matches your experience.

1. If you had urges to gamble during the past 30 days, on average, how strong were your urges?

<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
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2. During the past 30 days, about how often did you experience urges to gamble?

<input type="checkbox"/> Never	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Often	<input type="checkbox"/> Always or Nearly Always
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3. During the past 30 days, about how often were you preoccupied with your urges to gamble?

<input type="checkbox"/> Never	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Often	<input type="checkbox"/> Always or Nearly Always
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4. During the past 30 days how often were you able to control your urges?

<input type="checkbox"/> Never	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Often	<input type="checkbox"/> Always or Nearly Always
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5. During the past 30 days, how often did you think about gambling or placing bets?

<input type="checkbox"/> Never	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Often	<input type="checkbox"/> Always or Nearly Always
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6. During the past 30 days, how often were you able to control your thoughts about gambling?

<input type="checkbox"/> Never	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Often	<input type="checkbox"/> Always or Nearly Always
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7. During the past 30 days, how much trouble (relationship, financial, legal, job, medical, emotional) has your gambling caused you?

<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
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8. During the past 30 days, have you bet money, bought lottery ticket(s), or engaged in some form of gambling?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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9. Which of the following statements best compares the amount of gambling you have done in the past 30 days to before enrolling in treatment

<input type="checkbox"/> Much Less	<input type="checkbox"/> Less	<input type="checkbox"/> About the Same	<input type="checkbox"/> More	<input type="checkbox"/> Much More
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10. During the past 30 days, how many days have you gambled?
_____ days

11. During the past 30 days, how much money have you lost or won gambling?

Amount lost _____

Amount won _____

**12. During the past 30 days, how many Gambler’s Anonymous meetings have you attended?
_____ meetings**

Place an “X” in the column to rate how satisfied you are at this time with each topic in your life.

	Very Dissatisfied	Dissatisfied	Neutral	Satisfied	Very Satisfied
Job or school					
Friendships					
Family life					
Recreational activities					
Amount of time spent gambling					
Amount of money spent gambling					
Self-esteem					
Physical health					
Emotional health					
Spiritual well being					
Decision making abilities					
The place where you live					
The amount of money you have to buy what you need					
Your ability to take care of yourself (staying healthy, eating right, avoiding danger)					

13. During the past 30 days, to what extent did you have morbid thoughts (i.e. wishing you were dead) without thinking of suicide?

<input type="checkbox"/> Never	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Often	<input type="checkbox"/> Always or Nearly Always
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14. During the past 30 days, to what extent did you have thoughts of suicide?

<input type="checkbox"/> Never	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Often	<input type="checkbox"/> Always or Nearly Always
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Thank you for completing this form.

Counselor Name: _____ Client ID# _____ Clt. Zipcode _____
 Gender: ___ Age: ___ Ethnicity: _____ Marital Status: _____ Emp: _____
 Cycle: Initial 3-Month 6-Month 9-Month 12-Month 15-Month 18-Month 21-Month 24-Month
 _____ Discharge

If Discharge, type of discharge: Treatment Completed, Left Against Clinical Advice (Lost Contact), Non-compliance with Agency Rules, Transferred to Another Facility, Terminated by Facility, Choose to Decline Additional Treatment, Client Seen for Assessment Only, Client Moved, Administrative Discharge, Incarcerated, Death

Treatment received during current period: Individual Family/Couple Group Psychiatric