

## SAT - Person Affected by Problem Gambler Self Assessment Tool

Today's Date: \_\_\_\_\_

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

**1. Is the problem gambler in your life receiving counseling?**

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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**2. To the best of your knowledge is the problem gambler in your life still gambling?**

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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**3. Are you attending GamAnon?**

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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**4. Is the problem gambler attending Gamblers Anonymous?**

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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**5. 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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**6. 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#** \_\_\_\_\_

**Gambler ID#** \_\_\_\_\_ **Client 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 this period:**  Individual  Family/Couples  Group