



### Gambling Enrollment Assessment

▶ <b>ESM Client ID:</b>
<b>Provider ID:</b>

▶ <b>Enrollment Date:</b> /    /
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All questions marked with ▶ must be completed. Boxes marked with ★ = Refer to Keys

▶ <b>1. First Name:</b>		<b>Last Name:</b>	
▶ <b>2. Intake/Clinician Initials:</b> <input type="checkbox"/> <input type="checkbox"/>			
▶ <b>3. Number of days between initial contact with the program by the client or someone on behalf of the client and enrollment :</b> (unknown = 999)		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
▶ <b>4. Source of Referral:</b> <input type="checkbox"/> <input type="checkbox"/> ★	<b>4a. Client Type (Check one)</b> <input type="checkbox"/> Primary <input type="checkbox"/> Collateral	<b>4b. Psycho-education Client?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>	
▶ <b>5. Do you have children?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused <input type="checkbox"/> Unknown <input type="checkbox"/>			
<i>If answer to question 5 is 'Yes', complete 5a - 5c. If no, skip to Question 6.</i>			
5a. Number of Children Under 6: <input type="checkbox"/>		5b. Number of Children 6-18: <input type="checkbox"/>	5c. Children Over 18: <input type="checkbox"/>
▶ <b>6. Employment status at Enrollment:</b> <input type="checkbox"/> ★		▶ <b>7. Days worked past month?</b> <input type="checkbox"/> <input type="checkbox"/>	
▶ <b>8. Where do you usually live? (Check one - If client is currently homeless, enter shelter or street)</b>			
<input type="checkbox"/> 01 House or apartment	<input type="checkbox"/> 03 Institution	<input type="checkbox"/> 05 Shelter/mission	<input type="checkbox"/> 07 Foster Care <input type="checkbox"/> 99 Unknown
<input type="checkbox"/> 02 Room/boardng house	<input type="checkbox"/> 04 Group home	<input type="checkbox"/> 06 On the streets	<input type="checkbox"/> 88 Refused
▶ <b>9. Who do you live with? (Check all that apply)</b>			
<input type="checkbox"/> Alone	<input type="checkbox"/> Child under 6	<input type="checkbox"/> Child over 18	<input type="checkbox"/> Parents <input type="checkbox"/> Roommate/Friend
<input type="checkbox"/> Child 6-18	<input type="checkbox"/> Spouse/Equiv	<input type="checkbox"/> Other Relative	<input type="checkbox"/> Unknown
▶ <b>10. Use of mobility aid? Check all that apply</b>			
<input type="checkbox"/> None	<input type="checkbox"/> Crutches	<input type="checkbox"/> Walker	<input type="checkbox"/> Manual wheelchair <input type="checkbox"/> Electric wheelchair
▶ <b>11. Vision Impairment:</b> <input type="checkbox"/> ★ <b>12. Hearing Impairment</b> <input type="checkbox"/> ★ <b>13. Self Care/ADL Impairment</b> <input type="checkbox"/> ★ <b>14. Mental Retardation</b> <input type="checkbox"/> ★			
<b>15. Prior Mental Health Treatment:</b> 0 <input type="checkbox"/> No History    01 <input type="checkbox"/> Counseling    02 <input type="checkbox"/> One Hospitalization    03 <input type="checkbox"/> More than one hospitalization			
▶ <b>16. During the past 12 months, did you take any prescription medication that was prescribed for you to treat a mental or emotional condition?</b> 01 <input type="checkbox"/> Yes    02 <input type="checkbox"/> No    88 <input type="checkbox"/> Refused    99 <input type="checkbox"/> Unknown			
▶ <b>17. Number of prior admissions to each substance abuse treatment modality</b>			
Detox: <input type="checkbox"/>	Residential: <input type="checkbox"/>	Outpatient <input type="checkbox"/>	Opioid: <input type="checkbox"/> Drunk Driver: <input type="checkbox"/> Other: <input type="checkbox"/> Unknown: <input type="checkbox"/>
▶ <b>18. Currently receiving services from a state agency: (Check all that apply)</b>			
<input type="checkbox"/> None	<input type="checkbox"/> DCF	<input type="checkbox"/> DYS	<input type="checkbox"/> DOC <input type="checkbox"/> MPB <input type="checkbox"/> OCP <input type="checkbox"/> DMH <input type="checkbox"/> DDS
<input type="checkbox"/> DPH	<input type="checkbox"/> DTA	<input type="checkbox"/> DMA/MassHealth	<input type="checkbox"/> EEC <input type="checkbox"/> MRC <input type="checkbox"/> MCB <input type="checkbox"/> MCDHH <input type="checkbox"/> Other

#### Q 12 Employment Status at Enrollment

Code		Code		Code	
1	Working Full Time	6	Not in Labor Force - Retired	11	Volunteer
2	Working Part time	7	Not in Labor Force - Disabled	12	Other
3	Unemployed - looking	8	Not in labor force - Homemaker	13	Maternity/Family Leave
4	Unemployed - Not Looking	9	Not in labor force - Other	99	Unknown
5	Not in labor force - Student	10	Not in labor force - Incarcerated		

<b>▶ 19. Gambling History:</b>											
	Ever Gamble		Age: 1st Bet	Last Bet <i>See Code*</i>	Freq. of Last Bet <i>See Code*</i>		Ever Gamble		Age: 1st Bet	Last Bet <i>See Code*</i>	Freq. of Last Bet <i>See Code*</i>
	Y	N					Y	N			
A	Lottery -Scratch Tickets					G	Lottery/Numbers Games				
B	Casino Games					H	Sports Betting				
C	Dog/Horse Tracks, Jai Alai					I	Internet Gambling				
D	Lottery - Keno					J	Slot Machines				
E	Card Games					K	Bingo				
F	Stock Market					L	Other				
<b>▶ 20. Rank gambling by entering corresponding letter for preferred type of gambling. Use letter listed above in Question 19.</b> <i>(If no secondary or tertiary gambling choice, leave blank)</i>											
▶ 20a. Primary Gambling Type <input type="checkbox"/> 20b. Secondary Gambling Type <input type="checkbox"/> 20c. Tertiary Gambling Type <input type="checkbox"/>											
<b>▶ 21. Has gambling caused you to have legal problems?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>											
<b>▶ 22. What is the number of times in your lifetime that your gambling has led to you being arrested?</b>											
<b>▶ 23. T1. Tobacco Use?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused <input type="checkbox"/> Unknown <input type="checkbox"/> <i>If answer to T1 is 'Yes' complete T2-T4. If 'No' skip to Question 24</i>											
T2. Age of first use: <input type="checkbox"/> T3. Last Use: <input type="checkbox"/> T4. Number of cigarettes smoked per day? (indicate number of cigarettes, not number of packs: 1 pack = 20 cigarettes): <input type="checkbox"/>											
<b>▶ 24. Have you ever used alcohol or drugs regularly? (check all that apply)</b>											
1	<input type="checkbox"/> None	F	<input type="checkbox"/> Non Rx Methadone	L	<input type="checkbox"/> Other Stimulants	R	<input type="checkbox"/> Over the Counter				
A	<input type="checkbox"/> Alcohol	G.	<input type="checkbox"/> Other Opiates/Synthetics	M	<input type="checkbox"/> Benzodiazepines	S.	<input type="checkbox"/> Club Drug				
B	<input type="checkbox"/> Cocaine	H.	<input type="checkbox"/> PCP	N	<input type="checkbox"/> Barbiturates	U	<input type="checkbox"/> Other				
C	<input type="checkbox"/> Crack	I.	<input type="checkbox"/> Other Hallucinogens	O	<input type="checkbox"/> Other Tranquilizers	V	<input type="checkbox"/> Oxycodone				
D	<input type="checkbox"/> Marijuana/Hashish	J.	<input type="checkbox"/> Methamphetamine	P	<input type="checkbox"/> Other Sedatives/Hypnotics	W	<input type="checkbox"/> Non-Prescription Suboxone				
E	<input type="checkbox"/> Heroin	K	<input type="checkbox"/> Other Amphetamine	Q	<input type="checkbox"/> Inhalants						
<b>▶ 25. Rank substances by entering corresponding letter for substances listed above in Question 24. (If no secondary or tertiary substance, leave blank)</b>											
▶ 25a. Primary Substance <input type="checkbox"/> 25b. Secondary Substance <input type="checkbox"/> 25c. Tertiary Substance <input type="checkbox"/>											
<b>▶ 26. Needle Use?</b>											
0	<input type="checkbox"/> Never	1	<input type="checkbox"/> 12 or more months ago	2	<input type="checkbox"/> 3 to 11 months ago	3	<input type="checkbox"/> 1 to 2 months ago	4	<input type="checkbox"/> Past 30 days	5	<input type="checkbox"/> Last week

Q5. Source of Referral at Enrollment					
Code	Code		Code		
01	Self, Family, Non-medical Professional		19	Other Substance Abuse Treatment	
02	BMC Central Intake – Room 5		20	Health Care Professional, Hospital	
03	ATS - Level A		30	School Personnel, School System	
04	Transitional Support Services		40	Supervisor/Employee Counselor	
05	CSS – Clinical Stabilization Services		50	Shelter	
06	Residential Treatment		51	Community or Religious Organization	
07	Outpatient SA Counseling		60	Court - Section 35	
08	Opioid Treatment		61	Court - DUI	
09	Drunk Driving Program		62	Court - Drugs	
10	Acupuncture		63	Court - Other	
11	Gambling Program		64	Prerelease, Legal Aid, Police	
12	Sec 35 (WATC and MATC)		65	County House of Correction/Jail	
13	Youth Program		66	Office of Community Corrections	
14	Sober House		67	Dept. of Corrections	
15	Information and Referral		68	Dept. of Probation	
17	Second Offender Aftercare		69	Massachusetts Parole Board	
			70	Dept. of Youth Services	
			71	Dept. of Children and Families	
			72	Dept. of Mental Health	
			73	Dept. of Developmental Services	
			74	Dept. of Public Health	
			75	Dept. of Transitional Assistance	
			76	Dept. of Early Education and Care	
			77	Mass. Rehab. Commission	
			78	Mass. Commission for the Blind	
			79	Mass. Comm. For Deaf & Hard of Hearing	
			80	Other State Agency	
			81	Division of Medical Assistance/MassHealth	
			99	Unknown	

Q19. Gambling History Questions							
Code		Last Bet				Frequency of Last Bet	
1	12 or more months ago	4	Past 30 days		1	Less than once a month	
2	3-11 months ago	5	Last week		2	1-3 times a month	
3	1-2 months ago	6	Today		3	1-3 times a week	

Code		Q. 11 Vision Impairment	
0	None: Normal Vision		
1	Slight: vision can be or is corrected with glasses/lenses		
2	Moderate: "Legally blind" but having some minimal vision		
3	Severe: No usable vision		

Code		Q. 12 Hearing Impairment	
0	None: Normal hearing requiring no correction		
1	Slight: Hearing is or can be adequately corrected with amplification (eg hearing aid)		
2	Moderate: Hard of hearing, even with amplification		
3	Severe: Profound deafness		

Code		Q13. Self Care/ADL Impairment	
0	None: No problem accomplishing ADL skills such as bathing, dressing and other self care		
1	Slight: Uses adaptive device(s) and/or takes additional time to accomplish ADL but does not require attendant		
2	Moderate: Needs personal attendant up to 20 hours a week for ADL		
3	Severe: Requires personal attendant for over 20 hours a week for ADL		

Code		Q14. Mental Retardation	
0	None		
1	Slight retardation		
2	Moderate retardation		
3	Severe retardation		

Code		T2 Frequency of Last Use	
1	Less than once a month	5	Daily
2	1-3 times a month	6	None
3	1-2 times a week		
4	3-6 times a week		

Code		T2 Last Use of Tobacco	
1	12 or more months ago	7	Refused
2	3-11 months ago	8	Unknown
3	1-2 months ago		
4	Past 30 days		
5	Last Week		
6	Today		

Code		T4. Interest in Stopping Tobacco use	
1	No, not thinking of stopping		
2	Yes, within next 6 months		
3	Yes, within next 30 days		
4	Does not apply (already stopped)		
88	Refused		
99	Unknown		