Gapp Counseling Services, LLC

Intake Form: *Please fill out all information you believe would be helpful for your treatment. Please be as thorough as you can.* ***Thank you, Deb Gapp***

Gapp Counseling Services (GCS) will not discriminate based on race, color, creed, national origin, ancestry, citizenship, gender, sexual orientation, religion, age, or disability.

Date: _____/_____/_____ **File#**: _____
(for GCS use only)

Name: _____ _____ _____
First Middle Last

Age:_____

Date of birth: _____/_____/_____ **Place of birth:** _____

Gender: _____ Male _____ Female **Last 4 digits of your Soc Security Number:** __ __ __ __

Marital Status: ❒ Single, Never Married ❒ Married ❒ Divorced
❒ Separated ❒ Widowed ❒ Cohabitating

Spouse's Date of birth: _____/_____/_____

Are you a veteran? ____Yes _____No

Which branch? Please check all that apply
__ Army __ Navy __ Air Force __ Marines __ Coast Guard _____ Other ☐ **Active** ☐ **Reserves** ☐ **Guards**

Where have you served? _____

Race/Ethnic Origin: **(Check one)**
☐ **White/Caucasian** ☐ **Asian/Asian American** ☐ **Pacific Islander** ☐ **African American/ Black**
☐ **Hispanic/Latino** ☐ **Other (please specify)** _____
☐ **Native American/ American Indian** ☐ **Tribal Member (Name of Tribe)**_____

Address: _____
Street City State

_____
Zip Code County

Home Phone: _____ **E-mail address:** _____

Work Phone: _____ **Cell Phone:** _____

How may GCS contact you?

❒ Home phone ❒ Work phone ❒ Cell phone ❒ Mail ❒ E-mail ❒ Fax

In case of psychological or medical emergency, whom should we contact?

Contact Name: _____ Relationship: _____

Phone: _____City/State: _____

Reason for coming to Gapp Counseling Services

Many factors affect a person's life, career choice, ability to concentrate, work or academic performance and overall well-being. Please check all that apply:

A. ____ I am concerned about my own _____mental health
_____ alcohol and drug use

B. ____ I am concerned about someone else's _____mental health
_____ alcohol and drug use

C. ____ I am concerned about my relationship(s) ____loss, ____conflict,____mistreatment/abuse

D. ____ I am experiencing grief due to loss/death of a family member, friend, or significant other

E. ____ I am being referred to have an alcohol and drug use assessment.

F. ____ Other (please explain):_____

In your own words, please summarize the concerns that bring you to Gapp Counseling Services:

_____

_____

Since approximately what date have you been having these issues?_____

How did you hear about Gapp Counseling Services? _____

History of Mental Health and Alcohol or Other Drug Services

Have you had a psychological and/or alcohol or drug assessment in the past? ❒ Yes ❒ No

Are you <u>currently</u> receiving services from a psychiatrist, psychologist, counselor, chemical dependency professional, social worker, pastor, or other mental health practitioner for personal, mental health and/or drug and alcohol concerns? ❒ Yes ❒ No

Please indicate all the services you have participated in (currently or in the past) for your own and/or someone else's mental health concerns and/ or alcohol and drug use:

Age	Type of Treatment	Name And City/State Location Of Provider	Length Of Time You Received Services	Dates of Service
	Individual or group counseling			
	Psychological Evaluations			
	Alcohol or other Drug Assessments			
	Education or diversion programs for alcohol or other drug use (i.e. DUI classes)			
	Inpatient or Intensive Outpatient Treatment for substance abuse			
	Psychiatric service with a psychiatrist (i.e. medication management)			
	Psychiatric hospitalization			

	Self-help or support groups			

Indicate your level of concern on all situations that apply to you. Please check the corresponding box.	**NO CONCERN**	**LITTLE CONCERN**	**MODERATE CONCERN**	**EXTREME CONCERN**
1. Insomnia (problems falling or staying sleep, waking early)				
2. Nightmares				
3. Death of someone significant in my life				
4. Feeling sad, empty, and crying for no reason				
5. Thought or worries that keep racing around in my head				
6. Fatigue or decreased energy				
7. Think and speak more slowly than normal				
8. Have trouble concentrating, remembering, and making decisions				
9. Lost interest in things I once enjoyed				
10. Preoccupied with death and/or suicide				
11. Feeling helpless, guilty, or worthless				
12. Hopelessness or pessimistic feelings				
13. Loss of pleasure in usual activities				
14. Irritability				
15. Persistent thoughts of death				
16. Trembling, restlessness, rapid heartbeat				
17. Difficulty paying attention				
18. More active than normal, and tend to act without thinking				
19. Difficulty with listening and speaking				
20. Difficulty with reading, writing and spelling				
21. Difficulty doing math calculations				
22. Extreme distractibility				
23. Significant risk-taking				
24. Increased energy, activity, rapid talking & thinking, agitation				
25. Decreased need for sleep without fatigue				
26. Unrealistic belief in one's own abilities				
27. Increased sex drive				
28. Excessive anger				
29. Trouble with major relationship				
30. Job is too stressful				
31. Feel overwhelmed by life				

32. Difficulty managing major life decisions				
33. Bothered by thoughts of insanity				
Indicate all of the behaviors that apply to you. Please check the corresponding box.	**NO CONCERN**	**LITTLE CONCERN**	**MODERATE CONCERN**	**EXTREME CONCERN**
34. Thoughts of killing myself				
35. Thoughts of self harm/cutting myself				
36. Hearing voices no one else can hear or see objects or things no one else can see				
37. Nightmares or flashbacks because of a traumatic/terrible event.				
39. Experience any strong fears				
40. Experienced emotional problems due to sexual interests, activities, or partners				
41. Aggressive urges or impulses that I do not like having				
42. Slow in getting acquainted with people				
43. Not knowing how to study effectively				
44. Worried about a member of my family				
45. Hard to study in living quarters				
46. Not mixing well with the opposite sex				
47. Trouble in keeping a conversation going				
48. Slow in reading				
49. Unable to discuss certain problems at home				
50. Can't forget some mistakes I've made				
51. Getting into trouble with authorities				
52. Wondering if I'll find a suitable mate				
53. Being ill at ease with other people				
54. Doubting the wisdom of my vocational choice				
55. Being criticized by my parents				
56. Not knowing what I really want				
57. Thinking too much about sex matters				
58. Wanting more worthwhile discussions with people				
59. Lacking confidence in my parenting abilities				
60. Clash of opinions between me and my parents				
61. Wanting more chance of self-expression				

Indicate all of the behaviors that apply to you. Please check the corresponding box.	**NO CONCERN**	**LITTLE CONCERN**	**MODERATE CONCERN**	**EXTREME CONCERN**
62. Concerns about my use of tobacco, alcohol, or drugs				
63. Concerns about other's use of tobacco, alcohol or drugs				
64. Wanting love and affection				
65. Being left out of things				
66. Concern over amount of debt I owe				
67. Confused in some of my religious beliefs				
68. Afraid to speak up in class discussions				
69. Not reaching the goals I've set for myself				
70. Too little social life				
71. Frustrated with household chores not done				
72. Disliking financial dependence on others				
73. Feelings of being "pushed around"				
74. Speaking or acting without thinking				
75. Finding it hard to talk about my troubles				
76. Wanting a more pleasing personality				
77. Fearing failure in college				
78. Financial problems				
79. Being timid or shy				
80. Not knowing where I belong in the world				
81. Lacking self-control				
82. Not being the kind of person I should be				
83. Family problems				

Have you ever thought of suicide? ❒ Yes ❒ No **Have you ever attempted suicide?** ❒ Yes ❒ No

If yes, number of times_____ Age ____Were alcohol and/ or drugs and /or medications involved? ❒ Yes ❒ No

Please explain the circumstances:

_____

_____

My current level of suicidal thought is (circle a number):

1 2 3 4 5 6 7 8 9 10

No risk moderate suicidal thoughts severe risk

Has a family member/friend/significant other attempted or committed suicide? ❒ Yes ❒ No

If yes, please explain the circumstances**:** _____

Have you had aggressive thoughts of hurting others in the past? ❒ Yes ❒ No

If yes please explain**:**_____

_____

My current level of aggressive thoughts of hurting others is (circle a number):

1 2 3 4 5 6 7 8 9 10
No risk some aggressive thoughts severe risk

MEDICAL/PHYSICAL INFORMATION

Do you consider your health to be: ❒ Excellent ❒ Good ❒ Fair ❒ Poor

Are you currently pregnant? ❒ Yes ❒ No ❒ Don't know

Past Pregnancies? ❒ Yes ❒ No

Your current weight _____ **Your current height** _____

Are you currently under the care of a health care provider such as a physician, psychiatrist, chiropractor, or other health practitioner? ❒ Yes ❒No

Where (or with whom): _____

Purpose: _____

Do you have any physical disabilities? ❒ Yes ❒ No If yes, please specify:_____

Have you had any significant illnesses or injuries now or in the past? ❒ Yes ❒ No

Age of illness of injury Type of illness of injury

_____

_____

_____

Are you currently taking any prescribed medications for medical conditions or psychotropic medications for mental health concerns? ❒ Yes ❒ No

Name of medication and why do you take it: Dosage:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Do you take your current medications as prescribed? …… ❒ Yes ❒ No
Do you take outdated or previously prescribed medications? …… ❒ Yes ❒ No

Have you ever misused or abused over-the-counter or prescription medications? ❒ Yes ❒ No
If yes, please explain: _____

Have you used prescription, over-the-counter, herbal, or illicit drugs to help with insomnia, keep you awake, help you to relax, help you to study, or to cope with a personal problem?
❒Yes ❒ No If yes, please explain:_____

_____

Are you covered under a health insurance plan? ❒ Yes ❒ No
If yes, please indicate if the insurance is: Employment-related ____ Private ____ Other ____

Name of health insurance provider: _____

Please indicate which of the following you have now or have had in the past:

	Never	One time	Occasional	Recurrent		Never	One Time	Occasional	Recurrent
Headaches					Malnutrition				
Earaches					Hepatitis				
Respiratory Problems					Seizures				
STDs (Sexually Transmitted Diseases)					Hypoglycemia				
Cirrhosis or other liver problems					Diabetes				

Do you have any allergies? ❒ Yes ❒ No

If yes, to what are you allergic?

❒ Milk/Dairy ❒ Soy ❒ Latex ❒ Pollen ❒ Dog/cat dander
❒ Wheat ❒ Shellfish ❒ Mold ❒ Airborne ❒ Medication
❒ Corn ❒ Nuts/Peanuts ❒ Dust ❒ Other _____

Have you experienced weight fluctuations in the past year? ❒ Yes ❒ No

In regards to food or to control your weight, have you ever:

❒ stopped eating/hardly ate at all ❒ binged
❒ purged (vomit) ❒ dieted
❒ used laxatives ❒ thought about food frequently
❒ exercised excessively ❒ been on diet plans (i.e. Weight Watchers, Nutri-System)
❒ loss of appetite ❒ used herbal or other weight control products to control weight (i.e. Hydroxy Cut)

TB Risk Assessment

Have you experienced any of the following in the last 3 months?

1. An **unexplained** cough lasting 2-3 weeks that produces sputum such as: ❒ Yes ❒ No
   (Green, Yellow, White-Creamy, Clear, Blood-tinged, Dark red blood, Bright red blood)
2. **Unexplained** night sweats ❒ Yes ❒ No
3. **Unexplained** fevers ❒ Yes ❒ No
4. **Unexplained** weight loss ❒ Yes ❒ No

EDUCATIONAL

Please list all of your educational experiences.

Name of SCHOOL	**Year of Graduation**	How were your grades? (Poor, Fair, Good, or Excellent)	Did you have any alcohol or drug related problems in school?	Did you have any learning or academic problems?
Elementary School				
Middle School				
High School				
Vocational, Technical, College or University (1)				
Vocational, Technical, College or University (2)				
Other/Additional education				

Do you have a learning disability? ❒ Yes ❒ No ❒ Think I do, but never diagnosed

If yes, what types? ❒ Reading ❒ Writing ❒ Math ❒ Attention ❒ Other _____

Did/has your use of alcohol/other drugs kept you from going to school, or negatively affected your academic performance?

❒ Yes ❒ No If yes, how many times _____ If yes, please explain: _____

Have personal or mental health concerns or the medications prescribed to treat them, kept you from going to school, or negatively affected your academic performance? ❒ Yes ❒ No

If yes, how many times? _____ If yes, please explain:

_____**Have you ever been suspended or put on probation by any school/university/technical school due to your alcohol use or personal behaviors?** ❒ Yes ❒ No **If yes**, ❒ Disciplinary ❒ Censure How many times? _____

Name of school/university/technical school:_____

Please explain: _____

Because of your substance use have you attended school or had your academic performance effected by any of the following conditions? If yes, please indicate the number of times of occurrence:

	Intoxication	High	Hangover	Missed class	Undone homework	Poor grades
Alcohol						
Drugs						

VOCATIONAL

Please complete the following information concerning your major employment (including current or most recent)

Age	Employer	Job Title & Duties	Salary (per hour, week, or month)	Reason for leaving (better job, fired, etc.)

Because of your substance use have you gone to work or had your work performance effected by any of the following conditions: If yes, please indicate the number of times of occurrence:

	Intoxicated	High	Hangover	Missed work	Conflict at work	Unfinished work	Poor performance
Alcohol							
Drugs							

Have you ever been fired from a job or lost a job due to your alcohol or drug use and/or personal or mental health concerns? ❒ Yes ❒ No If yes, please explain:_____
_____

Have you not been hired for a job due to your alcohol or drug use and/or personal or mental health concerns? ❒ Yes ❒ No If yes, please explain:_____
_____

Have personal and/or mental health concerns and/or medication problems kept you from going to work, and/or negatively affected your job performance? ❒ Yes ❒ No If yes, please explain:_____
_____

FINANCIAL

Are you working? ❒ Yes ❒ No

If yes, where? _____
If yes, is your work ❒ fulltime ❒ part-time
Number of hours per week: _____

How long have you been employed/ unemployed? _____ years _____ months

Gross annual income: Self: $ _____ Household: $ _____

Sources of income: ❒ Employment ❒ Disability ❒ Family
❒ Pension ❒ Food Stamps ❒ TANIF
❒ Friend ❒ SSI ❒ Other _____

How much do you spend on alcohol? $ _____per week _____ in the past 12 months
How much do you spend on drugs? $ _____per week _____ in the past 12 months
How much do you spend on cigarettes or tobacco products? $ _____per week _____ in the past 12 months

Have you ever filed bankruptcy? Please discuss the situation briefly_____
_____

Have you ever experienced foreclosure of your home?
Have you ever had possessions repossessed?
If entering into counseling to resolve financial issues, please list current debts here:

Debt	Interest Rate	Monthly payment owed

LEGAL

Have you ever been arrested or had legal charges? ❒ Yes ❒ No

Date (dd/mm/yy):	Offense:	Convicted?
1. _____	_____	❒ Yes ❒ No
2. _____	_____	❒ Yes ❒ No
3._____	_____	❒ Yes ❒ No

Number of DWI (Driving While Intoxicated) or DUI (Driving Under Intoxication) arrests: _____

Date:	Blood Alcohol Level:	Consequences (fines, court costs, lawyer fees, community services, treatment, revocation/suspension of license, etc.)
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Number of other <u>alcohol/drug related</u> convictions (includes minor in possession, minor in consumption, open container, zero tolerance etc.): _____

Date:	Offense:	Consequences (fines, court costs, lawyer fees, community services, treatment, revocation/suspension of license, etc.)
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Please list other legal charges (i.e. false impersonation, disorderly house, assault, destruction of property, etc.)

1. _____
2. _____

Number of current pending alcohol/drug related charges: _____

Charge:	County:
1. _____	_____
2. _____	
3. _____	

Have you had any alcohol/other drug offenses that were reduced or changed to a non-alcohol/ other drug offense, (i.e. DUI to a reckless driving, possession to an ingestion, etc.)? ❒ Yes ❒ No

_____

_____

Have you had a violation of the USD or other University/College student code? ❒ Yes ❒ No
If yes, is that violation related to your request for services? ❒ Yes ❒ No

Date:	School Code Violation	Consequences (fines, alcohol education, community service, disciplinary censure, academic probation, assessment, etc.)
1. _____	_____	_____
2. _____	_____	_____

If applicable:

Name of attorney:	**Address:**	**Phone:**
_____	_____	_____

What is your court date (if applicable)? _____County:_____

SOCIAL

Number in household: _____

Do you live: ❒ alone ❒ with spouse only ❒ with family
❒ with unrelated person(s) ❒ with parent/sibling ❒ with significant other

Do you live in: ❒ your own home ❒ university housing ❒ family member's home
❒ rental house ❒ trailer house ❒ apartment complex
❒ rented room ❒ other (please specify) _____

With whom do you usually talk over your problems or plans?

_____

_____

How many of your friends are local? _____

If your closest friends are not close by, where are they?_____

Do you consider yourself to have: ❒ many, ❒ few, or ❒ very few acquaintances?

_____

In what activities, community, or civic organizations do you participate?

_____

What kind of hobbies, interests, social activities, or activities do you like to do?

_____

What percentage of your friends use? alcohol _____ drugs_____

What percentage of your social activities involve? alcohol _____ drugs _____

If you use alcohol and/or drugs, how would your friends respond if you were to quit using alcohol and/or drugs?_____

_____

Do your personal concerns have a negative effect on your relationships or your social life? ❒ Yes ❒ No
If yes, please describe:_____

_____

Do you have a significant relationship in your life? ❒ Yes ❒ No

Briefly describe that relationship:_____

FAMILY INFORMATION

Please provide the following information regarding your family, i.e., parents, step-parents, brothers, sisters, husband or wife, and children. You may also include ex-spouses, current significant others etc. as you see appropriate.

Relationship	Name	Age	Occupation	Education	Single	Married	Divorced	Widowed	Deceased

Check all that describe your immediate family/family of origin/home environment:

❒Flexible ❒Rigid ❒Relaxed atmosphere ❒Tense atmosphere

❒Open system ❒Closed system ❒Fun, joy, playful ❒Grim, serious

❒Individuality encouraged ❒Conformity encouraged ❒Intimacy sought ❒Intimacy avoided

❒Feelings expressed ❒Feelings constricted ❒Autocratic decision-making ❒Democratic decision-making

❒Focus on behaviors and performance ❒Respected

❒Balance of focus on feelings, behavior and performance

If there is a family history of mental health problems and/or a significant alcohol, drug or gambling problem, abuse, or addiction, please check all that apply:

Family Member ➔ Condition🡻	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Mother	Father	Any Bio-Brother	Any Bio-Sister	Any Bio-Aunts	Any Bio-Uncles
Anger										
Anxiety										
Depression										
Major Depression										
Sleep Problems										
Thought problems										
Schizophrenia										
Bipolar Disorder										
Self-harm										
Eating Disorders										
Physical Abuse										
Sexual Abuse										
Emotional Abuse										
Domestic Violence										
Gambling Problems										
Alcohol Problems										
Drug Problems										

Were any of the above conditions treated with medications, counseling, psychiatric services, hospitalization, substance abuse treatment (others), or not at all? Please explain:

_____

_____

_____

SPIRITUAL BELIEFS

Describe your spiritual beliefs:

_____

_____

To what, if any, church, religious organization, movement, or group do you belong?

_____

To what degree do you participate in your spiritual beliefs? _____

In what way, if any, do your spiritual beliefs affect your substance use and/or your views on personal or mental health problems? _____

PERSONAL HISTORY OF SUBSTANCE USE

The substances that I have used are (rank in order the substances with 1 being the most frequently used, 2 being the next most frequently used, etc).

____ Alcohol
____ Marijuana/Cannabis
____ Steroids
____ Methamphetamine
____ Opiates (non-prescription opiates)
____ Hallucinogens (LSD, mushrooms- Psilocybin, Peyote, Mescaline
____ Prescription opiates (Demerol/Vicodin/Oxycontin/Tylenol with codeine, etc.)
____ Over-the-counter medication (cough syrups, ephedrine/ephedra, diet pills, DXM, etc.) for the sole purpose of getting high or intoxicated.
____ Stimulants/other amphetamines
____ Sedatives
____ Nitrous oxide
____ Cocaine
____ Inhalants
____ PCP

I have used substances in the following manner:

❒ Smoked ❒ In tea or food form ❒ Injected into muscle or vein
❒ Drank ❒ Inhaled through nose ❒ Inhaled through mouth

Have you ever used a needle to inject alcohol, illegal drugs or steroids? ❒Yes ❒ No

❒ Injected in the vein ❒ Injected in a muscle

If you have injected substances, have you ever used a needle after someone else used the needle? ❒Yes ❒ No

In your lifetime, have you been taken to a hospital (Emergency Room or Admissions) for alcohol poisoning?

❒Yes ❒ No **If yes, date of occurrence(s):_____**

In your lifetime, have you been taken to a hospital (Emergency Room or Admissions) for an illicit drug overdose?

❒Yes ❒ No **If yes, date of occurrence(s):_____**

In your lifetime, have you ever had an alcohol poisoning or an illicit drug overdose that was not treated at an emergency room or by admit to a hospital?

❒Yes ❒ No **If yes, date of occurrence(s):_____**

Indicate all of the behaviors that apply to you. Please check the corresponding box.	**Alcohol**	**Cannabis/ Hashish/ Marijuana**	**Nicotine**
1. What was your age of first use?			
2. What was your age of first intoxication?			
3. What is the greatest amount you have ever used in a single setting?			
3a. In days, hours or minutes, what length of time did you use the greatest amount?			
4. How old were you at the time of the greatest amount used?			
5. When was the last time you used? Give date			
6. In the past year, what was the greatest amount used?			
7. Explain your method of use (smoking, chew, injecting, drinking, etc.)			
8. Please mark all days you use the substance: please write the number of drinks those days, number of cigarettes, number of joints/bowls/hits, etc.			
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			
9. Do you believe you have a tolerance to this substance? (Tolerance means you need more of the substance to get high/buzzed/feel the effects, or you don't stay high as long as you used to with the same amount)			
10. Do you exhibit physical symptoms of withdrawal when recovering from the effects of, or when you stop using any of these substances? (headache, nauseous, anxious, irritable, want more of the substance, shakes, etc.)			
11. Have you ever had bizarre sensory sensations from your use of this substance? i.e. seeing, hearing, or tactile experiences that you cannot explain: unformed images, strange smells, something under or on your skin, unidentified sounds or noises			

Indicate all of the behaviors that apply to you. Please check the corresponding box.	**Alcohol**	**Cannabis/ Hashish/ Marijuana**	**Nicotine**
12. Have you ever had loss of control from use of this substance? Fights – physical or verbal, very emotional experience that could include anger or sadness or sobbing, periods of paranoia while drinking, "dancing on the table," doing physical – risky – sexual – activities you normally would not do. (please write number of times)			
13. Have you had blackouts from this substance? (# of times)			
14. Have you passed out from this substance? (# of times)			
15. Have you ever hallucinated from this substance? (# of times)			
16. Have you experienced symptoms of confusion, disorientation or seeing/hearing things that are not present?			
17. Have you ever had delusions from this substance (delusion is a false belief about something – paranoid – suspicious, etc)? (# of times)			
18. Have you ever had medical detox from this substance (including alcohol poisoning or acute alcohol intoxication from alcohol? (# of times)			
19. Have you ever tried to cut down or control your use of this substance (do not include times you cut back do to sports)? (# of time)			
20. Have you ever attempted to quit on your own from this substance? (# of times)			
21. Has your psychological health been affected by this substance?			
22. Has your physical health been affected by this substance?			
23. Has anyone complained about your use of this substance? (number of people – who has complained) i.e. 5/mom-dad/bfriend			
24. Use of this substance has caused me to take part in physical/verbal fights or violence			
25. I have driven a motorized vehicle after consuming this substance (# of times in a year)			
26. I have operated work machines (farm implements, saws, drills, welders, fryers, etc.) after consuming this substance			
27. I have engaged in physically hazardous activities after consuming this substance (swimming, skydiving, hunting, sports etc.)			
28. Percent of time that I use more of this substance than intended			
29. I spend more time **obtaining** this substance than I think or others tell me is appropriate (yes or no)			
30. I spend more time **using** this substance than I think or others tell me is appropriate (yes or no)			

Indicate all of the behaviors that apply to you. Please check the corresponding box.	Alcohol	Cannabis/ Hashish/ Marijuana	Nicotine
31. The amount of time it takes me to recover from this substance is greater than I think or others tell me is appropriate			
32. I have lost friends because of using this substance			
33. I have had to change friends due to using this substance			
34. I have lost a job or did not get a job due to this substance use (includes urinalysis, DUI – problems getting insurance, etc.)			
35. I have lost the ability to participate in sports or recreational activities due to this substance use			
36. A healthcare professional (physician, psychiatrist, counselor, pharmacist, etc.) has told me that this substance use is not appropriate because of a medical or psychological problem that would be made worse due to this substance or that using this substance with certain medications is not appropriate			

GAMBLING HISTORY

Have you ever gambled? ❒Yes ❒No

If yes, describe your gambling habits (check all that apply):

Bet with friends on sports or other events. ❒Yes ❒No If yes, how many times? _____

Bet with "Bookies" on sports or other events. ❒Yes ❒No If yes, how many times? _____

Play cards or throw dice for money. ❒Yes ❒No If yes, how many times? _____

Travel to casinos and play slot machines. ❒Yes ❒No If yes, how many times? _____

Travel to casinos and play at the tables/cards or roulette. ❒Yes ❒No If yes, how many times? _____

Play video lottery machines in stores and shops. ❒Yes ❒No If yes, how many times? _____

Play video lottery machines in food establishments. ❒Yes ❒No If yes, how many times? _____

If yes, what age were you when you first placed a bet? _____

If yes, what is the greatest amount you ever lost gambling? _____

If yes, what is the greatest amount you ever won gambling? _____

If yes, when was thelast time you gambled? _____

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