PATIENT NAME		PATIENT ID#	!	ADMISSION DATE
PREPARED BY (IF OTHER THAN QPGP):	TITL	E:	SIGNATURE: & DA	TE ((WITHIN 2 WEEKS OF ADMISSION):
COORDINATING QUALIFIED PROBLEM GAMBLING PROFESSIONAL:	CRE	EDENTIAL:	SIGNATURE: & DA	TE (WITHIN 2 WEEKS OF ADMISSION):
PATIENT'S PRESENTING PROBLEM:				
GAMBLING HISTORY: Include age of onset, duration/frequency of gambling, gambling history of previous attempts to stop gambling, patient's own percuse been impacted by or how has it influenced gambling behavior	ception	of gambling, self	f-help involvement, prior i	treatment history, how has psychoactive chemical
FINDINGS AND CONCLUSIONS:				

PATIENT NAME:	ID#	
SUICIDAL / HOMICIDAL MENTAL HEALTH /		
EMOTIONAL HEALTH:		
SUICIDAL / HOMICIDAL: Include past suicide attempts; method; suicide plan;		
EMOTIONAL HEALTH: Include patient lethality, i.e., if patient is a danger to him	n/herself or others, history of hospitalizations, lengths of stay, suicide attempts, ing physician – indicate current status; history of mental abuse or emotional abuse,	
ability to express emotions, emotional state	ing physician indicate current status, motory of montal abase of chickonal abase,	
FINDINGS AND CONCLUSIONS:		
FINANCIAL STATUS:		
Include assessment of any gambling debt and any previous bankruptcy and/ or re payment plans.		
FINDINGS AND CONCLUCIONS.		
FINDINGS AND CONCLUSIONS:		

PATIENT NAME:	ID#
LEGAL INVOLVEMENT:	
Include current/pending legal issues w/scheduled court appearances, parole/proba	ation status, precipitators and when legal involvement will end.
FINDINGS AND CONCLUSIONS:	
EMPLOYMENT / EDUCATION/ VOCATION:	d, GED status, degrees obtained, strong and weak subjects, adjustment problems in
school, learning disabilities and skills learned in trade school, the military or while in	
FINDINGS AND CONCLUSIONS:	

PATIENT NAME:	ID#	
FAMILY: Indicate relationship with family members, peers and significant others, family dynamics and composition – include history and impact of gambling ( and any alcohol and/or substance us) by family members, significant others and by peer group; family mental health history, family trauma issues, significant others in treatment, birth order, cultural and ethnic background, loss/abandonment issues.		
FINDINGS AND CONCLUSIONS:		
HOUSING:		
Indicate current housing / living arrangements.		
FINDINGS AND CONCLUSIONS:		

PATIENT NAME:	ID#	
SOCIAL / LEISURE / RECOVERY: Include all leisure activities, hobbies and interests, past and present; individuals we encourage socialization; include access and any participation in the recovery continuous con	with whom the patient associates; address activities which are isolating and do not nmunity; access to religious/pastoral care; include clients strengths and assets:	
FINDINGS AND CONCLUSIONS:		
ACTIVITIES OF DAILY LIVING:  Address personal hygiene and appearance, money and time management, managing medication, general responsibilities, i.e., paying bills, keeping home clean, keeping appointments, proper nutrition, caring for children, transportation, accessing community services, etc.		
FINDINGS AND CONCLUSIONS:		
TIME INCO / IND CONCESSIONS.		

PATIENT NAME:	ID#	
MEDICAL / HEALTH / HIV and AIDS; TB, HEPATITIS, OTHER COMMUNICABLE DISEASE RISK ASSESSMENT:  Include date of last physical examination, medical history, current medical problems/chronic medical conditions, current medications, nutritional information including regular daily diet, dental history, etc., Include any knowledge on harm reduction techniques and safer sex practice - include history of tuberculosis, hepatitis, HIV, or other STDs or infectious disease.		
FINDINGS AND CONCLUSIONS:		
FINDINGS AND CONCLUSIONS:		
detoxification, inpatient rehabilitation, outpatient treatment, etc. Also include histor others.	tors, e.g., peer pressure, depression, life crisis, increased tolerance, wn perception of chemical use, self-help involvement, prior treatment history, e.g.,	
FINDINGS AND CONCLUSIONS:		

PATIENT NAME:	ID#
TOBACCO USE, ABUSE, AND DEPENDENCE HISTOR Smoking history, include age of onset, duration/frequency of use, administration, tolerance, consequences of use, history of previous attempts to remain abstinent, history, etc. Also include history of use of tobacco by and the impact of the use of	patterns, precipitators, e.g., peer pressure, depression, life crisis, increased , patient's own perception of tobacco use, self-help involvement, prior treatment
FINDINGS AND CONCLUSIONS:	
OTHER: Indicate other relevant factors which may aid in treatment plan development, i.e., terrorism) military history; veteran's status; history of domestic violence; physical dissues such as isolation, interaction issues; etc.	
FINDINGS AND CONCLUSIONS:	

Names of All Individuals who participated in this evaluation.				
	DSM IV DIAGNOSES			
	AXIS	AXIS		
l:		II:		
l:		III:		
		(if applicable)		
l:		IV:		
	Axis I co-occurring mental health disorder(if applicable)	(if applicable)		
l:		V:		
	Axis I co-occurring mental health disorder(if applicable)	(if applicable)		