

**Nebraska Gamblers Assistance Program
GAP DATA AT DISCHARGE - Family Member Client**

Your answers are confidential. Thank you.

Agency Name: _____ Date: _____

CLIENT DOB: ____/____/____	CLIENT ID:
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Have you experienced any of the following outcomes of counseling? (Check all that apply)	<input type="checkbox"/> Help with financial problems <input type="checkbox"/> Regained connection with family member with gambling problem <input type="checkbox"/> Decreased emotional distress <input type="checkbox"/> Improved communication	<input type="checkbox"/> Improved social life <input type="checkbox"/> Improved health <input type="checkbox"/> Clarity about life choices <input type="checkbox"/> Reduction of problem gambling behavior <input type="checkbox"/> Elimination of problem gambling behavior
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What is your relationship to the family member with a gambling problem?	<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner <input type="checkbox"/> Child <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Parent
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How many sessions did you complete before you knew counseling would help you?	<input type="checkbox"/> 1 - 6 <input type="checkbox"/> 7 - 12	<input type="checkbox"/> 13 - 21 <input type="checkbox"/> 21 +
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What is the primary reason you are ending counseling?	<input type="checkbox"/> Family member has not gambled for a significant period <input type="checkbox"/> Family member continues to gamble <input type="checkbox"/> Family member and I have separated <input type="checkbox"/> Family member and I have divorced <input type="checkbox"/> Family member and I have ceased communications	<input type="checkbox"/> Family member started counseling for his/her gambling problem <input type="checkbox"/> Problem gambling is no longer an element in my life <input type="checkbox"/> Counselor and I agree counseling is at an end <input type="checkbox"/> I am ready <input type="checkbox"/> Counseling is not meeting my needs nor expectations
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Did your family member continue to gamble while you were in counseling?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Did your family have gambling debt when you started counseling?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Today, approximate gambling debt (nearest 1,000): \$ _____
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How would you describe your gambling debt in comparison to when you started counseling?	<input type="checkbox"/> Decreased <input type="checkbox"/> No change <input type="checkbox"/> Increased
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Is your family member's problem gambling	<input type="checkbox"/> Worse? <input type="checkbox"/> Unchanged? <input type="checkbox"/> Better?
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Living Situation:	<input type="checkbox"/> Living with family member with gambling problem <input type="checkbox"/> Living with relative <input type="checkbox"/> Living alone <input type="checkbox"/> Remarried
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Employment:	<input type="checkbox"/> Employed full time for salary or wages <input type="checkbox"/> Employed part time for salary or wages <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Self-employed <input type="checkbox"/> Disability <input type="checkbox"/> Student
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Did you attend any self-help support groups for family members of people with a gambling problem during counseling?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Are you interested in finding a self-help support group to help you after counseling has ended?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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How important was it that problem gambling counseling was paid for?	<input type="checkbox"/> Major factor <input type="checkbox"/> Minor factor <input type="checkbox"/> Not a factor
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Did you request or participate in any online counseling sessions with your counselor?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Do you feel counseling met your needs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Will you return to counseling if gambling becomes a problem for you again?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Since you have started treatment, has your spouse or intimate partner threatened to harm you?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable
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Since you have started treatment, has your spouse or intimate partner physically harmed you?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable
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Since you have started treatment, have you threatened to harm your spouse or intimate partner?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable
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Since you have started treatment, have you physically harmed your spouse or intimate partner?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable
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The following questions ask you to compare your life situation when you started counseling and your life today:

How would you describe your financial status today compared to when you started counseling?	<input type="checkbox"/> Worse <input type="checkbox"/> No change <input type="checkbox"/> Better
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How would you describe the relationship with your friends today compared to when you started counseling?	<input type="checkbox"/> Worse <input type="checkbox"/> No change <input type="checkbox"/> Better
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How would you describe your alcohol use today compared to when you started counseling?	<input type="checkbox"/> Lower <input type="checkbox"/> No change <input type="checkbox"/> Higher <input type="checkbox"/> Not applicable
How would you describe your tobacco use today compared to when you started counseling?	<input type="checkbox"/> Lower <input type="checkbox"/> No change <input type="checkbox"/> Higher <input type="checkbox"/> Not applicable
How would you describe your drug use today compared to when you started counseling?	<input type="checkbox"/> Lower <input type="checkbox"/> No change <input type="checkbox"/> Higher <input type="checkbox"/> Not applicable
How would you describe your gambling today, if any, compared to when you started counseling?	<input type="checkbox"/> Lower <input type="checkbox"/> No change <input type="checkbox"/> Higher <input type="checkbox"/> None
How would you describe your sense of well-being today compared to when you started counseling?	<input type="checkbox"/> Worse <input type="checkbox"/> No change <input type="checkbox"/> Better
How would you describe your overall physical health today compared to when you started counseling?	<input type="checkbox"/> Worse <input type="checkbox"/> No change <input type="checkbox"/> Better
How would you describe your relationship with your family member with a gambling problem today compared to when you started counseling?	<input type="checkbox"/> Worse <input type="checkbox"/> No change <input type="checkbox"/> Better <input type="checkbox"/> Not applicable
How would you describe your relationship with your children or other family members today compared to when you started counseling?	<input type="checkbox"/> Worse <input type="checkbox"/> No change <input type="checkbox"/> Better <input type="checkbox"/> Not applicable
How would you describe your relationship with your friends today compared to when you started counseling?	<input type="checkbox"/> Worse <input type="checkbox"/> No change <input type="checkbox"/> Better <input type="checkbox"/> Not applicable
How would you describe your outlook today compared to when you started counseling?	<input type="checkbox"/> Bad <input type="checkbox"/> No change <input type="checkbox"/> Good

