

**Nebraska Gamblers Assistance Program  
GAP DATA AT DISCHARGE – Gambler Client**  
Your answers are confidential. Thank you.

Agency Name: \_\_\_\_\_ Date: \_\_\_\_\_

<b>CLIENT DOB:</b>	<b>CLIENT ID:</b>	
If your goal for GAP treatment was to quit gambling, were you successful in meeting your goal?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
If your goal for GAP treatment was to gamble responsibly, were you successful in meeting your goal?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
What is the <b>primary</b> reason you are ending counseling? <b>(Select ONE)</b>	<input type="checkbox"/> I want to gamble without limits <input type="checkbox"/> I met my goals for treatment <input type="checkbox"/> I gamble responsibly now	
How many hourly 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 +
Did you attend any self-help support groups for people with a gambling problem during counseling?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
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	
Did you request or participate in any telehealth counseling sessions with your counselor?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you feel that your counseling met your needs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Will you return to counseling if gambling becomes a problem for you again?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

<b>The following questions ask you to compare your life situation when you started counseling and your life today:</b>	
How would you describe your <b>gambling</b> today compared to when you started counseling?	<input type="checkbox"/> Lower <input type="checkbox"/> No change <input type="checkbox"/> Higher <input type="checkbox"/> Not gambling at all
How would you describe your <b>financial status</b> today compared to when you started counseling?	<input type="checkbox"/> Worse <input type="checkbox"/> No change <input type="checkbox"/> Better
How would you describe the <b>relationship with your family and friends</b> today compared to when you started counseling?	<input type="checkbox"/> Worse <input type="checkbox"/> No change <input type="checkbox"/> Better

**THIS PAGE TO BE COMPLETED BY THE COUNSELOR**

End of counseling date:	Date last seen:
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Client has had how many hourly counseling sessions?	
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Date client began long-term counseling?	
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End of counseling status:
<input type="checkbox"/> Counseling complete – agency decision <input type="checkbox"/> Counseling complete – client decision <input type="checkbox"/> Counseling complete – agency and client decision <input type="checkbox"/> Partial completion – agency decision <input type="checkbox"/> Partial completion – client decision <input type="checkbox"/> Client inaccessible <input type="checkbox"/> Referred to different counselor or agency. Client referred to: _____

DSM 5 Score:
<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9
<i>(DSM 5 score must match level of gambling severity.)</i>

<b>Counselor’s rationale for client’s status response:</b>

**DISCHARGE FORM REVIEWED BY COUNSELOR FOR COMPLETENESS** (please sign and date below):

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**