

BRIEF SCREENING INSTRUMENT
FOR
PATHOLOGICAL GAMBLING (BSIPG)

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Client Name: _____ Age: _____

Marital Status: _____ Occupation: _____

Date of Screening: _____ Assessor: _____

Screening Instrument for Pathological Gambling (SIPG)

During the past 6 months:

1. Have you gambled? Yes___ No___
2. Have you ever felt that you gamble too much? Yes___ No___
3. Have you ever tried to quit or cut down on your gambling? Yes___ No___
4. Have you ever sought out help for your gambling (for example, see a therapist or counselor, a treatment program, gamblers anonymous, etc.)? Yes___ No___
5. Have you ever had any of the following symptoms before, during, or after gambling:
 - ___Headaches?
 - ___Felt shaky?
 - ___Felt a crawling sensation under your skin after you stopped gambling?
 - ___Drank alcohol heavily?
 - ___Used any type of drugs?
 - ___Had a memory loss?
 - ___Felt butterflies or a nervous feeling in your stomach?
 - ___Felt chest pains?
 - ___Felt heart palpitations?
 - ___Difficulty breathing?
6. Has your gambling created problems with your spouse or other family members? Yes___ No___
7. Has your gambling ever caused problems at school or work? Yes___ No___
8. Have you ever had any type of legal problems because of your gambling? Yes___ No___
9. Have you ever lost your temper, got into fights, or arguments while gambling or after a heavy loss? Yes___ No___
10. Do you find yourself gambling more frequently hoping to win back your losses? Yes___ No___
11. Do you find yourself thinking about gambling more frequently? Yes___ No___

