PROBLEM GAMBLING
NEW YORK STATE
RESOURCE CENTERS
Here to Help

Client Session Record: Problem Gambling Treatment

Client Name: ______________________________

Month/Year of Sessions: ______________________

Treatment Providers, please indicate session dates.
Clients, please initial each date indicating your attendance on that date.

________	________	________	________
Date of service	Client Initials	Date of service	Client Initials
Date of service	Client Initials	Date of service	Client Initials
Date of service	Client Initials	Date of service	Client Initials
Date of service	Client Initials	Date of service	Client Initials

Client Survey:

Are your sessions helpful? YES or NO: ____________

Are you progressing towards your goal(s)? YES or NO: __________

Signatures by both parties indicate sessions occurred on the dates listed above for participation with a NYS Problem Gambling Resource Center Network Clinician. I hereby attest that the information completed by me in this for is true and correct to the best of my knowledge.

Client Name: ______________________

Client Signature: ______________________ Date Signed: __________

Treatment Provider Name: ______________________

Treatment Provider Signature: ______________________ Date Signed: __________