



INTAKE FOR ANGER MANAGEMENT 818

A. GENERAL INFORMATION

Client Name: _____ Date of Birth: _____

Sex: M F Marital Status: _____

What is the presenting problem? _____

How long have you had issues around anger? _____

Have you had any experience with past counseling? Yes No. If yes, when was the last time? And for how long? _____

Please list medical conditions and any medications you take. _____

Are you experiencing financial problems? Yes No _____

Are you experiencing any legal problems? Yes No _____

Was this court mandated? Yes No. If yes, how many weeks? _____

Do you have troubles at work stemmed from your anger? Yes No _____

Who do you have as your support system (friends and family)? _____

Did you witness violence in your home as a child? Yes No. If yes, please describe. _____

Were you ever involved with a gang? Yes No

Are you in a relationship with someone who has a problem with alcohol or drugs? Yes No

B. PSYCHOLOGICAL INFORMATION

1. How would you rate your level of energy? Low Regular High
2. Do you experience any sleep disturbance? Yes No. If yes, please check all that apply: Difficulty falling asleep Waking up too early and not being able to go back to sleep. Sleeping too much- over 8-9 hours daily. Not being able to sleep for more than 3 hours per night for a few nights consecutively.
3. Have you experienced any appetite changes in the past two weeks? Yes No. If yes, please check one that applies: Increase in appetite Decrease in appetite.
4. Do you find yourself getting easily irritated? Yes No
5. How would you rate your self esteem? Low Medium High
6. Do you experience feelings of hopelessness? Yes No
7. Do you experience feelings of helplessness? Yes No
8. Do you have a history of psychiatric problems? Yes No. If yes, please describe: _____
9. Are you a danger to yourself now? Yes No. Have you ever attempted suicide? Yes No. Ever hospitalized? Yes No. If so, when? _____
10. Do you have a history of violent behavior? Yes No. If yes, please describe your recent violent behaviors. _____

11. Is there a family history of: Suicide: Yes No _____
 Depression: Yes No _____
 Violence: Yes No _____
12. Do you go on uncontrollable shopping sprees? Yes No.
13. Do you gamble? Yes No. If yes, how often? _____
14. Do you have obsessions or compulsions? Yes No. If yes, please describe.

C. DOMESTIC VIOLENCE

1. Are you in a relationship? Yes No. If yes, for how long? _____
2. Are you married? Yes No Cohabiting? Yes No. If yes, how long did you date before moving in or getting married? _____
3. Have you ever hit your partner? Yes No
4. Have you ever broken anything, or punched walls in their presence? Yes No
5. Is there any name calling? Yes No. If yes, what kind of names? _____
6. Any threats, such as “If you ever leave me, I’m going to kill you.” Yes No
7. Any put downs, such as “If you leave me, no one else would take you.” Yes No
8. Do you make promises after blow ups, such as promising to get help. Yes No
9. Do you get along with your partner’s family and/or friends? Yes No

D. SUBSTANCE ABUSE SCREEN

1. What types/frequency of drugs (including prescription) and alcohol have you used? _____
2. Do you think you’re a normal drinker? Yes No
3. Have you ever had memory problems following drinking the night before? Yes No
4. Does any member of your family ever worry or complain about your drinking or drug use? Yes No
5. Are you able to stop drinking or using when you want? Yes No
6. Have you ever attended AA or other 12 step or drug/alcohol treatment programs? Yes No. If yes, which ones? _____
7. Has drinking or drug use ever created problems between you and your partner or other family members? Yes No
8. Have you ever missed work or other obligations because of drinking? Yes No
9. Is there a family history of alcohol or drug problems? Yes No