



Anger Management of the Upstate

Intake Form - Parenting

Please print. Answer **ALL** questions. Initial each page.

Date: _____

DEMOGRAPHICS

Name: _____ DOB: _____

Address: _____ City: _____

State: _____ Zip code: _____ Phone: _____

Email: _____ Referred by: _____

Marital status: Single Married Divorced Separated

Living Arrangements: Living with partner Living alone Living with family

Living with friend Homeless

How long have you lived in current residence? _____ Rent Own

List all the people that live with you in the chart below.

	Name	Age	Relationship to you
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

List your children in the chart below.

	Name	Age	Gender
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Initial: _____

CHILDHOOD HISTORY

By whom were you raised? Check all that apply. Mother Father Grandmother

Grandfather Step mother Step father Relatives Foster Care

Adopted Other _____

Is any of your parent(s)/guardian(s) deceased? Please list which one(s) (ex. mother, father etc.)

Is your relationship with your parent(s)/guardian(s) close or distant? Explain relationship with each.

Did you experience any traumatic events during your childhood? (ex. death, abuse, etc.) No Yes

If yes, please explain _____

Explain how you came to leave home. _____

Number of siblings: _____

Is your relationship with your siblings close or distant? Explain: _____

Were you or any of your siblings physically, psychologically, or sexually abused as children? No Yes

By whom? _____

What was the impact emotionally and psychologically on the abused? _____

Did you have any problems with anger or violent behavior as a child or teenager? No Yes

Initial: _____

If yes, please explain _____

Were there any events or circumstances regarding your childhood that may help us understand your particular counseling needs? No Yes If yes, please explain: _____

Did your parents/guardians physically and/or psychologically abuse each other? No Yes

If yes, please explain: _____

What impact did seeing/hearing one of your parent's/guardian's abuse to each other have on you emotionally, psychologically and/or physically? Please explain: _____

FAMILY ORIGIN

Describe what the following people do/did with their anger, especially when you were growing up.

Your father/father figure: _____

Your mother/mother figure: _____

Your siblings: _____

Other significant person(s): ex. grandparents _____

Is there any family history of bad temper, assaults, homicides or suicides? No Yes

If yes, explain: _____

In general, what did you learn from your family about anger? _____

Initial: _____

EDUCATION

Highest grade completed: _____ GED High School diploma College degree

If you dropped out of school explain why? _____

EMPLOYMENT

Current Employer: _____ Job Title: _____

Length of employment: _____ Salary (hourly) _____ or (annually) _____

MEDICAL/HEALTH

Do you have any ongoing health problems? No Yes Explain: _____

Are you currently taking any medications? No Yes List meds: _____

ALCOHOL AND/OR DRUG HISTORY

At what age did you have your first drink of alcohol and/or drugs? _____

What did you use? _____

Do you currently drink alcohol and/or use drugs? No Yes

If yes, what did you use? _____

How often did you use? _____ How much? _____

If you do not currently drink or use drugs, have you ever drank alcohol and/or use drugs? No Yes

How long ago did you quit? _____ For what reasons did you quit? _____

Have you received a DUI? No Yes How many? _____

What was your Blood Alcohol Level on your last one? _____

Have you ever received treatment for alcohol or drug abuse/dependence? No Yes If yes, when and where were you in treatment? _____

Did you successfully complete treatment? Yes No If not, why not? _____

Initial: _____

Are you still abstinent? Yes No If no, what triggered your relapse? _____

Where you drinking and/or using drugs during your most recent abusive episode? No Yes

Is the use of alcohol and/or drugs a problem in your relationship? No Yes

Do you need help for alcohol or drug abuse/dependency problems? No Yes

PSYCHIATRIC STATUS

Have you ever been treated for psychological or emotional problems? No Yes

If yes, for what were you being treated? _____

How long ago did you receive counseling or treatment? _____

Did you complete the program? Yes No If no, why not? _____

Have you experienced serious depression, sadness, hopelessness, loss of interest, difficulty with daily functions in the past 30 days? Yes No in your lifetime? Yes No

If yes, please explain? _____

Have you experienced serious anxiety, tension, up-tightness, stress, unreasonably worried, inability to relax? Yes No If yes, explain when was the last time and how often does it occur. _____

Have you experienced hallucinations, saw things or heard voices that were not there? Yes No
When was the last time your experienced hallucinations?

Have you experienced trouble understanding, concentrating, or remembering? Yes No
If yes, explain _____

Have you experienced trouble controlling violent behavior, including episodes of rage or violence?

Yes No When was the last time this occurred? _____

What usually triggers this behavior? _____

Have you experienced thoughts to suicide in the past 3 days? No Yes
in your lifetime? No Yes If yes, explain _____

Initial: _____ No Yes If yes, explain _____

Have you felt like hurting others or committing homicide? No Yes If yes, whom did you want to hurt? _____

What were the reasons? _____

Have you ever been prescribed medication(s) for any psychological or emotional problems? No Yes
If yes, for what was the medications prescribed?

Was the treatment successful? Yes No Explain: _____

Is there anything else you can tell me that might help us understand your anger and how it affects you and others?

Reviewed by: _____

Date: _____

Initial: _____