Anger Management of the Upstate

Intake Form - Parenting

Date: _____

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

DEMOGRAPHICS

Name: _____ DOB: _____

Address: _____ City: _____

State: _____ Zip code: _____ Phone: _____

Email: _____ Referred by: _____

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Seperated

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 employement: _____ 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 alchohol 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 receieved 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? _____

Were 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 situation and how it affects you and others?

_____

_____

_____

_____

_____

_____

Reviewed by: _____

Date: _____