& 4 Real Solutions 4 Real Problems Agency

Anger Management Intake & Assessment Form – Part 1

Care 4 His Creation / 4 Real Solutions 4 Real Problems

Participant Name: _____
Date of Birth: _____
Today's Date: _____
Phone Number: _____

Educational Background

1. **What was the highest grade you completed?**
   _____
2. **Can you read? [ ] Yes [ ] No**
3. **Would you like to return to school and finish where you left off? [ ] Yes [ ] No**
4. **Would you like to take classes to help you improve your reading? [ ] Yes [ ] No**

Anger History

5. **How long have you experienced issues with anger?**

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6. **Have you had any past counseling? [ ] Yes [ ] No**
    - **If yes, when was the last time? _____**
    - **For how long? _____**

Health Information

7. **Please list any medical conditions:**

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8. **Please list any medications you are currently taking:**

Personal Circumstances

9. **Are you experiencing financial problems? [ ] Yes [ ] No**
   If yes, please explain:
   _____
10. **Are you experiencing legal problems? [ ] Yes [ ] No**
    If yes, please explain:
    _____
11. **Was this program court-mandated? [ ] Yes [ ] No**

- **If yes, how many weeks were ordered? _____**

12. **Do you have troubles at work stemming from your anger? [ ] Yes [ ] No**
    If yes, please describe:
    _____

Family & Social Background

13. **Who do you have as your support system (friends, family, mentors, etc.)?**

14. **Did you experience violence while growing up? [ ] Yes [ ] No**
    If yes, please describe:
    _____

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

16. **Were you ever involved with a gang? [ ] Yes [ ] No**

17. **Are you currently in a relationship with someone who has a problem with alcohol or drugs?**
    [ ] Yes [ ] No

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Anger Management Intake & Assessment Form – Part 2

Section B : Psychological Information

Participant Name : _____
Date : _____

General Mental & Emotional Health

1. How would you rate your level of energy?
   [ ] Low [ ] Regular [ ] High

2. Do you experience sleep disturbances?
   [ ] Yes [ ] No

- If yes, check all that apply:
  [ ] Difficulty falling asleep
  [ ] Waking up too early and unable to return to sleep
  [ ] Sleeping too much (over 8–9 hours daily)
  [ ] Sleeping less than 3 hours per night for several nights in a row

3. Have you noticed any appetite changes in the past two weeks?
   [ ] Yes [ ] No
   - If yes, check one:
     [ ] 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
   - Helplessness? [ ] Yes [ ] No
   - Excessive guilt or shame? [ ] Yes [ ] No

Psychiatric & Trauma History

7. Do you have a history of psychiatric problems?
   [ ] Yes [ ] No
   If yes, please describe: _____
8. Have you ever been hospitalized for psychiatric or emotional concerns?
   [ ] Yes [ ] No If yes, when? _____
9. Have you ever attempted suicide?
   [ ] Yes [ ] No
10. Are you currently a danger to yourself or others?
    [ ] Yes [ ] No

11. Do you have a history of violent behavior?
    [ ] Yes [ ] No
    If yes, please describe: _____

12. Is there a family history of:

- Suicide: [ ] Yes [ ] No If yes, describe: _____
- Depression: [ ] Yes [ ] No If yes, describe: _____
- Violence: [ ] Yes [ ] No If yes, describe: _____

Behavioral Patterns

13. Do you go on uncontrollable spending sprees?
    [ ] Yes [ ] No

14. Do you gamble?
    [ ] Yes [ ] No
    If yes, how often? _____

15. Do you struggle with obsessions or compulsions (repetitive thoughts/behaviors)?
    [ ] Yes [ ] No
    If yes, please describe: _____

16. Do you struggle with addictive behaviors (alcohol, drugs, pornography, etc.)?
    [ ] Yes [ ] No
    If yes, please describe: _____

Stress & Coping

17. Do you experience frequent anxiety or panic attacks?
    [ ] Yes [ ] No
    If yes, how often? _____

18. What coping strategies do you usually use when you feel stressed or angry?

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19. Do you feel you have healthy ways to calm down when angry? [ ] Yes [ ] No

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RELATIONSHIP AND CONFLICT SCREENING (Domestic Violence) Part 3

1. Are you currently in a relationship? [ ] Yes [ ] No
   If yes, how long have you been together? _____
2. Are you married? [ ] Yes [ ] No
   Are you living with a partner? [ ] Yes [ ] No
   If yes, how long were you dating before moving in or marrying?
   _____
3. Have you ever physically harmed your partner? [ ] Yes [ ] No
4. Have you ever damaged property or struck objects during conflicts while your partner was present? [ ] Yes [ ] No
5. Do you or your partner engage in name-calling? [ ] Yes [ ] No
   If yes, what types of names are used?
   _____

6. Have there been threats of serious harm, such as “If you leave me, I’ll hurt you”? [ ] Yes [ ] No
7. Are there put-downs or demeaning statements, such as “No one else would want you”? [ ] Yes [ ] No
8. After conflicts, do you make promises to change, seek help, or improve your behavior? [ ] Yes [ ] No
9. How would you describe your relationship with your partner’s family or friends? [ ] Positive [ ] Neutral [ ] Negative

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D. SUBSTANCE USE SCREENING

1. What types of substances (including prescription medications, alcohol, or recreational drugs) have you used, and how frequently?
   _____
2. Do you consider yourself a regular alcohol consumer? [ ] Yes [ ] No
3. Have you experienced memory problems or blackouts after drinking? [ ] Yes [ ] No
4. Have family members expressed concern about your use of alcohol or other substances? [ ] Yes [ ] No
5. Are you able to stop using substances when you choose? [ ] Yes [ ] No
6. Have you participated in treatment programs (e.g., AA, NA, or other drug/alcohol programs)? [ ] Yes [ ] No
   If yes, which programs? _____
7. Has substance use caused problems in your relationships with partners or family? [ ] Yes [ ] No
8. Have you ever missed work, school, or other responsibilities due to substance use? [ ] Yes [ ] No
9. Is there a family history of alcohol or drug-related issues? [ ] Yes [ ] No

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E. SPIRITUALITY AND COMMITMENT TO CHANGE PART 4

1. Do you have spiritual or religious beliefs that are important to you? [ ] Yes [ ] No
   If yes, please describe: _____
2. Do you engage in spiritual practices, such as prayer, meditation, reading scripture, or attending religious services? [ ] Yes [ ] No
   If yes, how often?
   _____
3. Do you feel your faith or spirituality can support you in managing anger and making positive changes? [ ] Yes [ ] No
4. How committed are you to practicing the skills you learn in this program for lasting change? [ ] Very committed [ ] Somewhat committed [ ] Not committed
5. Are you willing to incorporate spiritual disciplines (prayer, meditation, scripture study) as part of your anger management and personal growth journey? [ ] Yes [ ] No

Goals Related to Spirituality and Change:

- Are you willing to Strengthen personal discipline in managing anger through spiritual and practical practices. Yes [ ] No [ ]
- Are you willing to apply faith-based principles, mindfulness, and healthy coping strategies in daily life. Yes [ ] No [ ]
- Are you willing to maintain accountability and a commitment to ongoing personal growth and lasting change. Yes [ ] No [ ]