OMEGA
MENTAL HEALTH
2549 W Shaw Ave
Fresno, CA 93711
Tel 559-290-7142
Fax 559-283-8166

Anger Management Intake

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. _____

_____

Do you take steroids? ☐ Yes ☐ No Do you take Testosterone? _____

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

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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.

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C. DOMESTIC VIOLENCE

1. Are you in a relationship? ☐ Yes ☐ No. If yes, for how long? _____
2. Are you married? ☐ Yes ☐ No Living together? ☐ Yes ☐ No. If yes, how long did you date before
3. moving in or getting married?_____
4. Have you ever hit your partner? ☐ Yes ☐ No
5. Have you ever broken anything, or punched walls in their presence? ☐ Yes ☐ No
6. 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