



Center of Solutions

P.O. Box 764
Holland, OH 43528

Phone: 888-606-1962

Anger Evaluation Intake Form

This form must be completed, signed & returned to Center of Solutions, LLC along with all of your anger evaluation materials.

Today's Date: _____

Personal Information:

Full Name: _____

Age: _____

Birth Date: _____

E-mail address: _____

Does anyone else have access to your e-mail address? Yes No

Mailing Address: _____

City: _____

State: _____

Zip: _____

Home Phone: _____

Work Phone: _____

Cell/Alternate Phone: _____

May we say who we are if we phone your home? (circle one) Yes No

May we say who we are if we phone your work? (circle one) Yes No

May we say who we are if we phone your Cell/alt number? (circle one) Yes No

Who is requiring you to take an anger evaluation?

What happened that made your anger come into question? (Please describe in detail)

How long has this problem been going on? (Please Explain)

Do you feel as though you have issues with anger?

How do you feel you handle your anger?

Any other additional comments or information I should know about you or your situation?

Circle Any of the Following That May Apply to You:

Headaches
Dizziness
Fainting Spells
No Appetite
Over-Eating Obsessions
Stomach Trouble
Suicidal Ideas
Always Tired
Always Sleepy
Unable To Relax
Insomnia
Recurrent Dreams
Nightmares
Hallucinations

Inferiority Feelings
Feel Tense
Feel Panic
Fears and Phobias

Depressed

Can't Make Decisions
Alcoholism
Dangerous Drugs
Gambling Addiction
Job Problems
Homosexuality
Sexual Problems

Shy With People
Can't Make Friends
Afraid Of People

Unable To Have A Good Time
Always Worried About Something
Don't Like Weekends/Vacations

Over-Ambitious
Financial Problems

Can't Keep A Job

Please explain any of the circled items:

Alcohol and Drug Use:

Do you use alcohol? How Much? How Often?

Prescription Medications:

Illegal Drugs What drug? How much? How often?:

Relationship Information

Relationship Status:

- Single
- Married
- Separated
- Divorced
- Committed relationship

Living Arrangement:

- Alone
- With Spouse
- With Roommate
- With Boyfriend/Girlfriend/Partner
- With Other Family

Close friend/relative we may contact in case of a true emergency :

Relationship to you: _____

Phone Address: _____

City State Zip: _____

Occupational/Educational Information:

What is your occupation? _____

Do you enjoy your job? (circle one) Yes No

All above information is accurate to the best of my knowledge.

Client name (print) Date Signature

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