12- week Anger Management Program
Client Intake Information
(To be completed by client)

Date_____

Name of Client	Home Phone	Business Phone	Social Security Number	D.O.B	Age
Street Address	Occupation		Education	Race/Ethnicity	Gender
City State Zip Code	Nearest Relative (Name & Address)				
Place of Employment			In case of Emergency, notify		

Present Marital or Relationship Status:

- ❑ Single
- ❑ Cohabiting
- ❑ Separated
- ❑ Widowed
- ❑ Significant Other
- ☐ Engaged
- ☐ Married
- ☐ Divorced
- ☐ Remarried

If married, how long? _____

Gross annual family income

Designated fees

Referral Source- Agency and individual

Other Agencies Involved

Family Members (Spouse, Children)

Name	Age	Grade/Occupation	Relationship	Living at Home?
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No

Clients' Family of Origin (Mother, Father, Brothers, Sisters)

Name	Age	Grade/ Occupation	Relationship	Living at client's home?
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No

PRESENTING PROBLEM (S): (State in your own words the reasons for which you are requesting help)