ATLANTA INTERVENTION NETWORK COUNSELING CENTERS

Dekalb/Tucker Center
5073 Lavista Road
Tucker GA 30084-3597

Newton/Covington Center
1115 Church Street (on Square)
Covington, GA 30014

Rockdale/Conyers Center
930 Green Street, SW
Conyers, GA 30012-5286

Gwinnett/Snellville Center
2386 Clower St, Bldg F, Suite 200
Snellville, GA 30078

Phone (770) 602-1979 Fax (770) 860-8315 Cellular (770) 713-8580

ANGER MANAGEMENT EVALUATION

Confidentiality: The information you give below will be held in strict confidence. It is to be used for the evaluation. You will need to sign a Release of Information or consent form first which will detail how the information will be used and what types of exceptions exist. Any false or misrepresented information places you at risk of being discharged.

Last name _____ First name _____ Middle initial _____

Date of birth _____ Age _____ Gender/Sex_____ Race _____

Social Security number ____-____-_____ Employer _____

Home Address _____ City _____ Zip _____

Phone: Home (____) _____ Work (____) _____ Cell (____) _____

1) Relative's phone: (_____) _____ 2) Relative's phone: (_____) _____

Do not write in this section–go to the next section (page)

Referred by _____*Evaluation by* _____

Class to attend: Day _____*Hour* _____ *Begin* _____

Recommendations _____

Form 3, Revised 6/07

CURRENT LIVING SITUATION

Check the box that most fits your situation:

- ☐ Single, never married.
- ☐ Single, but living with someone who is an intimate partner. How long? _____
- ☐ Married–How long? _____
- ☐ Is the person (parent, partner, spouse) you are living with supportive of you? ☐ Yes/ ☐ No.
- ☐ Separated? How long? _____ Do you think you will get back together? ☐ Yes/ ☐ No.
- ☐ Divorced? Dates of previous marriages: 1st from _____ to _____; 2nd from _____ to ____
- ☐ Children? Give age and gender (m/f): 1) _____ 2) _____ 3) _____ 4) _____ 5) _____
- ☐ Step-Children? Give age and gender (m/f): 1) _____ 2) _____ 3) _____ 4) _____
- ☐ Widow/Widower? Date of death? _____ Cause? _____

FAMILY BACKGROUND

Father: What does/did (if deceased) he do for a living? _____
Father: If deceased, when did he die? _____ What did he die from? _____
Mother: What does/did (if deceased)she do for a living? _____
Mother: If deceased, when did she die? _____ What did she die from? _____
Did your parents divorce? ☐ Yes/ ☐ No. When? _____ Did you have step-parent(s)? ☐ Yes/ ☐ No.
How many brothers and sisters do you have? _____ Step-brothers and sisters? _____
Did someone other than your parents raise you? ☐ Yes/ ☐ No. Who? _____

EDUCATION

- ☐ *Graduated* from high school in what year? _____
- ☐ *Did not* graduate from high school.
- ☐ GED? Received what year? _____ Seeking GED? ☐ Yes/ ☐ No.
- ☐ Attended college/technical school but did not graduate. How long? _____ Major_____
- ☐ Graduated from college/technical school in what year? _____ Major _____

EMPLOYMENT

- ☐ Currently employed and my employer is: _____ How long? _____
  Describe what you do: _____
  What other types of work have you done? _____
- ☐ Unemployed and seeking employment. What type of work are you seeking? _____
- ☐ Receiving financial assistance. What type? _____
  What did you do for a living previously? _____

MILITARY

- ☐ No military service.
- ☐ Branch of military service _____. Dates of service _____
- ☐ Special training? ____ What type? _____ Combat experience? _____
- ☐ Type of discharge? _____

FINANCIAL

Are you paying child-support? ☐ Yes/ ☐ No. Court-ordered? ☐ Yes/ ☐ No. Monthly amount _____
If you are in arrears, how much? _____
Have you ever declared bankruptcy? ☐ Yes/ ☐ No. If yes, when? _____

HEALTH

Do you have any physical limitations or disabilities? ☐ Yes/ ☐ No. If yes, describe _____
Did you take any type of medication? ☐ Yes/ ☐ No. What types? _____
Has any physician or psychiatrist ever diagnosed you as having depression, PTSD, bi-polar disorder, "nerves," attention deficit disorder or any similar type illness? ☐ Yes/ ☐ No. Which ones? _____
Have you ever been admitted to a psychiatric hospital? ☐ Yes/ ☐ No. Which one? _____
Did you take any medication? ☐ Yes/ ☐ No. What types? _____
Have any of your family members had any of the illnesses listed above? ☐ Yes/ ☐ No. Who? _____
What type of illnesses did they have? _____
Have you seriously considered harming yourself? ☐ Yes/ ☐ No. How close did you come?
_____
Have you seriously considered harming others? ☐ Yes/ ☐ No. How close did you come?
_____
Has anyone in your family committed suicide? ☐ Yes/ ☐ No. Who? _____

LEGAL

☐ **Currently on Probation**: What county? _____ Probation Officer's Name _____
What are you on probation for? _____ When were you arrested? _____
When were you sentenced? _____ How much time did you serve? _____
Fine $ ____ Community Service hours _____.D.V. Class _____. Length of Probation _____
Describe the events surrounding the arrest: _____
_____

☐ **Pending Charges**: What are the charges? _____
What county/city? _____ Do you have an attorney? ☐ Yes/ ☐ No. When do you go to court? ____ Describe the circumstances of the arrest: _____

☐ **Other Arrests**: List any other arrests you have including DUIs. You need to be accurate as possible so that if what you report is checked against your record it will not appear as if you were attempting to be evasive or hiding information.

	Charge	Date arrested	Date sentenced	Actual Sentence
1st Arrest				
2nd Arrest				
3rd Arrest				
4th Arrest				

ALCOHOL AND DRUG HISTORY QUESTIONNAIRE

Drinking/Using Pattern

Please answer the following questions on the basis of how you have drank alcohol or used drugs in the past 10 years. If you have not been drinking for a length of time, there will be a space to fill that in. We need to know how you have drank alcohol or used drugs in the past.

In the past, did your father drink (circle your response): heavily, moderately, lightly, never drank?
In the past, did your mother drink (circle your response): heavily, moderately, lightly, never drank?
How about any brothers or sisters? Heavily, moderately, lightly, never drink?

If you drank, where did you do most of your drinking? (Home, bars, parties, friend's home) _____

Have you ever tried to stop drinking or drugging? ☐ Yes/ ☐ No. If yes, how long did you go without drinking? ____ Why did you stop? _____

Have you ever had an alcohol or drug use evaluation before? ☐ Yes/ ☐ No. When? _____
Where? _____Why was the evaluation done? _____

Have you ever been in treatment for alcohol or drug related issues? ☐ Yes/ ☐ No. When and where did this take place? (Not including DUI School) _____

Have you ever been in an alcohol/drug-related halfway house? ☐ Yes/ ☐ No. When? __ Where?___

Have you ever been told by a doctor to stop drinking? ☐ Yes/ ☐ No.

Has anyone ever suggested to you that you should stop drinking? ☐ Yes/ ☐ No.

Do you typically drink alone? ☐ Yes/ ☐ No.

Do most of your friends drink? ☐ Yes/ ☐ No.

Have you ever attended an Alcoholics Anonymous (or CA, NA) meeting? ☐ Yes/ ☐ No.
Was it court-ordered? ☐ Yes/ ☐ No.

Does your partner or roommate drink? ☐ Yes/ ☐ No. (heavily, moderately, lightly, never drank?)

Have you been threatened about losing your job due to alcohol/drug related problems? ☐ Yes/ ☐ No.

In a one month (30 days) period, how many days would you drink? _____

Each time you drink, how much would you typically drink? _____

In a one week (7 days) period, how much would you drink? _____

When did you have your last drink? _____

Do you have hangovers? ☐ Yes/ ☐ No. How often? _____. Last hangover? _____

Have you ever used marijuana? ☐ Yes/ ☐ No. When was the last time you used it? _____

Have you ever used cocaine ☐ Yes/ ☐ No. When was the last time you used it? _____

Have you ever used methamphetamine ☐ Yes/ ☐ No. When was the last time you used it? _____

Have you ever used other illicit drugs not listed? ☐ Yes/ ☐ No. Which ones? _____

Have you ever abused prescription drugs? ☐ Yes/ ☐ No. Which ones? _____

Have you ever failed a drug screen (for example, at work or at probation)? _____

Have you sold drugs for profit or for your own use? ☐ Yes/ ☐ No. When? _____ How long?__

Do you think you have a problem with alcohol or drugs? Circle your response below.

No Problem 0 1 2 3 4 5 6 7 8 9 10 Very Serious Problem

What is the worst level of problem you reached while drinking or using drugs? Circle your response.

No Problem 0 1 2 3 4 5 6 7 8 9 10 Very Serious Problem

What is your present goal concerning drinking (or use of drugs)? ☐ Total abstinence (no drinking).
☐ Cutting back on drinking. ☐ Drinking the same amount. ☐ Not driving when drinking.

Do you think there are any questions/issues we might have missed that you would like to cover?

_____

_____

_____

_____

Print your name: _____

Sign your name: _____

Date: _____