



CLIENT INTAKE REFERRAL FORM RESET ANGER MANAGEMENT

Client Full Name: _____

DOB: _____ Age: _____ Gender: _____

Address: _____

City: _____ State: _____ Zip code: _____

Phone: _____ Email: _____

Can we contact you?

☐ Yes by phone ☐ Yes by text ☐ Yes by email ☐ No communication preferences

Preferred method:

☐ Call _____ ☐ Text _____ ☐ Email _____ ☐ Secure Portal _____

Referral Information (select one):

- ☐ Self-referral
- ☐ Court-ordered
- ☐ Attorney referral
- ☐ Probation/Parole referral
- ☐ Other agency: _____

If court ordered, court jurisdiction: _____

Case or docket # _____

Reason for Attending Anger Management:

What brings you here?



Recent concerns related to anger:

(Check all that apply) ☐ Relationship issues

☐ Work-related conflict

☐ Family conflict

☐ Emotional control problems

☐ Aggression/violence

☐ Difficulty expressing feelings

☐ Legal issues

☐ Other: _____

Previous Counseling or Anger Management?

☐ Yes ☐ No If yes, explain: _____

Client Signature: _____ Date: _____