CRAIG P. KURTZ LMHC, P.A
PROFESSIONAL COUNSELING CENTERS
JACKSONVILLE -ORANGE PARK
FLORIDA.

8 HOUR ANGER MANAGEMENT SELF ASSESSMENT:

Client Name: _____ Date of Birth: _____

I HAVE LEARNED THE FOLLOWING THINGS :

1.) WHAT IS ANGER?

_____

2.) EXPRESING ANGER IS:

_____

_____

_____

3.) WHERE DOES ANGER EXPERIENCE COME FROM:

_____

_____

_____

4.) RECOGNIZING ANGER MEANS?

_____

_____

_____

5.) WHAT IS EMOTIONAL INTELLIGENCE?

_____

_____

_____

6.) WHAT IS EMPATHY?

_____

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_____

7.) WHAT IS THE NEED FOR FORGIVENESS?

_____

_____

_____

8.) WHY DO I NEED SOCIAL NETWORKING?

_____

_____

_____

_

CRAIG P. KURTZ LMHC #5063, CAP# 20691 • ORANGE PARK, FL • JACKSONVILLE, FL
PHONE: (904) 525-5282, •

Name: _____

I _____ have realized from my past experiences and offense that should any further situations occur I will utilize the following course of action in managing my anger:

_____
_____
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_____

_____ Date: _____

Signed:

_____ Date: _____

Witnessed: Craig P Kurtz LMHC

,Please list them:

CRAIG P KURTZ LMHC #5063, CAP# 2069L • ORANGE PARK, FL • JACKSONVILLE, FL
PHONE: (904) 215-5282, •

Marital status: _____ Occupation: _____ Employer: _____ Home address: _____ Zip: _____ Home phone: _____ E-Mail: _____ Cell phone: _____ Referred by: _____ Reason: _____ OK to call in the event of an emergency __yes no __, we should call: _____ Phone: _____
Financial: Person assuming payment responsibility :_____Relationship to client: _____Gross Annual Income:____K

Employer:_____ Address: _____ Social Security #: _____Drivers License #: _____ Insurance referrals only, please complete the following:

Insurance Company: _____ Telephone: _____ Authorization #_____ Name of insured: _____ Insured date of Birth: _____ Insured SS#: _____ Certificate #: _____ Group #: _____ Secondary insurance: _____ , Please have insurance card ready for photocopying!

Psychiatric/Medical: Have you ever been in counseling/psychiatric care? ___ no ___ yes, When: _____ With whom: _____, May I contact them? ___yes___ no. Hospitalized for any reason? ___ no ___ yes. When? _____ Why? _____Any medical conditions? _____ Allergic to any medications? _____

By signing here I agree to the following_____Date: _____