TDMHDD/BOPP Community Treatment Collaborative Program
Simple Screening Instrument for anger management

Directions: The questions that follow are about anger management / stress. Your answers will be kept private. Mark the response that best fits for you. Answer the questions in terms of your experiences in the past 6 months.

During the last 6 months…

1. Have you ever harmed anyone because of anger?

   _______Yes ______No

2. During the last 6 months, have you ever harmed yourself when angry?
   ______ Yes ______ No

3. During the last 6 months, have you felt guilt or remorse after getting angry?
   ______ Yes ______ No

4. During the last 6 months, have you gone to anyone for help because of anger issues?
   ______ Yes ______ No

   a. If yes, please indicate the name of the program/counselor/organization providing help and the year you received this help:____

5. During the last 6 months, has a significant other threatened to leave because of your anger?
   _______Yes _______No

6. During the last 6 months, have you felt unable to control your anger?
   ______ Yes ______ No

7. During the last 6 months, has a friend or loved one said you have a problem with anger?
   ______ Yes ______ No

8. During the last 6 months, have you been arrested or had other legal problems? (Such as assault, domestic violence, etc.)
   ______ Yes ______ No

9. During the last 6 months, have you lost your temper or gotten into arguments or fights?
   ______ Yes ______ No

10. During the last 6 months, has any one voiced concern about your anger?
    ______ Yes ______ No

11. Are you frequently grumpy, sad, or moody?
    ______ Yes ______ No

12. During the last 6 months, have you felt alone or misunderstood?
    ______ Yes ______ No

13. During the last 6 months, has your behavior of angry thoughts made you feel hopeless or depressed?

_______ Yes _______ No

. **Questions #14, #15, and #16 are about your lifetime experiences.**

14. Have you ever lost a job due to your anger?
    _______ Yes _______ No

15. Have any of your family members ever had anger problems?
    _______ Yes _______ No

16. Do you feel that you have an anger problem?
    _______ Yes _______ No

Thank you for completing this questionnaire.

Scoring for the Anger Management Screening Instrument

Note: The scoring must be completed by the screener (not the consumer).

Consumer Name: ______________________________ Date: ________________________________

Social Security Number: _________________________

Screening Location: ____________________________ Screener Name: ______________________

Items 1, 14, and 14a are not scored. The following items are scored as 1 (yes) or 0 (no):

___ 2	___ 7	___ 12	
___ 3	___ 8	___ 13	
___ 4	___ 9	___ 15	*Score #5 as 1 if any
___ 5	___ 10	___ 16	Item is checked
___ 6*	___ 11	Total score: ______	(Score range: 0-14)

Check any of the following that you observe. Record any additional comments on the back of this form

- ☐ Needle track marks
- ☐ Skin abscesses, cigarette burns, or nicotine stains
- ☐ Tremors (shaking and twitching of hands / eyelids)
- ☐ Unclear speech (slurred, incoherent, or too rapid)
- ☐ Unsteady gait (staggering, off balance)
- ☐ Dilated (enlarged) or constricted (pinpoint) pupils
- ☐ Scratching
- ☐ Swollen hands or feet
- ☐ Smell of alcohol or marijuana
- ☐ Drug paraphernalia (pipes/papers/needles/roach clips)
- ☐ "Nodding off" (dozing or falling asleep)
- ☐ Agitation
- ☐ Inability to focus
- ☐ Burns on inside of lips (from freebasing cocaine)

Preliminary interpretation of score:**

Score	Degree of Anger Management Issues
0-1 and question 14a. is "NO"…… ………	No risk, Anger services not indicated
0-1 and question 14 and 14a. are "YES"….	Low risk, refer for anger support services
2-3 ………………………………………..	Minimal risk, refer for recovery support services
4 and above………………………………	Moderate to high risk, refer for a clinical assessment

Screener's referral outcome

If score is 4 or above, I have informed the consumer the score indicates the possible need for a clinical assessment and have taken the following action:

Consumer referred to: *(agency)*____

Date referred: ____

Date of assessment: ____

***Note:** *The above score combined with the observations are meant to be used as a guide in determining whether the consumer should be referred for a clinical assessment. The assessment will determine if clinical treatment is indicated and the level of care*

_______________________________________ ____________________

Screener signature Date

_______________________________________ ____________________

Consumer signature Date