

**CLIENT INTAKE FORM B**  
**PAGE ONE**

CLIENT NAME \_\_\_\_\_

**HEALTH DATA:**

Rate your physical health (check One)

VERY GOOD \_\_\_\_\_ GOOD \_\_\_\_\_ AVERAGE \_\_\_\_\_ POOR \_\_\_\_\_

List important illnesses, surgeries, or injuries which have caused you serious difficulty: \_\_\_\_\_

Date of last medical exam: \_\_\_\_\_

List or describe any medication and dosage now taken: \_\_\_\_\_

Your physician: \_\_\_\_\_

Address: \_\_\_\_\_

Previous counseling, psychotherapy, or spiritual direction: (Circle One) YES NO

If YES, list name(s) of counselor, therapist, or director: \_\_\_\_\_

Dates and numbers of sessions: \_\_\_\_\_

Previous serious mental disturbance or "nervous breakdown": (Check One) YES NO

If YES, were you hospitalized? \_\_\_\_\_

Are you now or have you ever been abused? \_\_\_\_\_

Are you now or have you previously been alcohol or drug dependent? \_\_\_\_\_

**(OVER)**

9/5/84

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