Treatment Resources for Youth, Inc.

2517 North Charles St. • Baltimore, Maryland 21218 • (410) 366-2123 • Fax (410) 366-0055

CLIENT'S NAME

1.	Date of Phase Intake:				
2.	Intake Worker:				
3.	Client Social Security #:				
4.	Date of Birth:	Age:		Race:	
5.	Sex:	Male		Female	
6.	Substances Used:				
7.	Has client had previous counseling for substance abuse or mental health issues?				

8. _____

Referral Agency or Person's Role

9. _____

Client lives with whom:

Check here if same as above: [ ]

10. _____

Parent or Guardian's Name:

11.	Client Mailing Address:		
12.	City:	14.	County/City:
13.	State:	15.	Zipcode:
16.	Day Phone:	17.	Other Phone:

18.	Screening Mode: [circle one]			
	Face to Face - Telephone - Written - N/A			
19.	Reason For Referral:			
20.	Court Date Pending?		Yes	No
	If yes-date:			
	Court Ordered? [circle one]		Yes	No
21.	Employed:[circle one]		Yes	No

COUNSELOR'S NAME

22.	In School? [circle one]	Yes	No
23.	Name of School:		
24.	Highest Grade Completed:		

25. _____

Referring Counselor / Probation Officer

26. _____

Mailing Address

27. _____

Phone Number

28.	DJJ : [circle one]		
	Is supervision?:	Formal	Informal
	If informal date ends:		

29.	Medical Insurance:	Yes	No
	Insurance #:		
	Company Name:		

30.	Comments:	

Dispostion:	DEFER	ADMIT
Date:		
TRY Counselor :		