



Treatment Resources for Youth, Inc.

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

CLIENT'S NAME

COUNSELOR'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?			

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

Referring Counselor / Probation Officer

Mailing Address

Phone Number

8. Referral Agency or Person's Role

26.

27.

9. Client lives with whom:
 Check here if same as above: []

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

10. Parent or Guardian's Name:

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

11.	Client Mailing Address:			
12.	City:	14.	County/City:	
13.	State:	15.	Zipcode:	

30.	Comments:			

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

Disposition:	DEFER	ADMIT
Date:		
TRY Counselor :		