|  |  |
| --- | --- |
| *Client Name:*Last | First |
| *Client #:* | SS#: - - | *D.O.B. / /* | *Age:*  | *Race:* | *Sex:* |
| *Health Information: check all that apply, review file for detail information* |
| \_\_\_ medication | \_\_\_ mental health concerns | \_\_\_ physical limitations | \_\_\_ special diet |
| \_\_\_ other (specify) |
| *Parent/Guardian(s) Information:* \_\_\_CINS/FINS \_\_\_ DCF |
| Mother/Casework name:  | Father/Supervisor name: |
| (M) Address:Street | (F) AddressStreet |
| City State Zip | City State Zip |
| (M) Phone-home: | (F) Phone-home: |
| (M) Phone-work/other: | (F) Phone-work/other: |
| *Emergency Contact/Recovery On-Call #:* |
| Name: | Phone #: |
| Approved Phone Contacts: check client file for details |
|  |  |
|  |  |
|  |  |
| *Not Approved for Any Contact:* |
|  |  |
| *IYP Counselor/Casemanager:* | Name:  |  |
| *Intake:* | Staff Name: | *Disposition:*  | Staff Name: |
| Date: | Time: | Date | Time: |