



**Lake County Children's Advocacy Center**  
**Client Information Form**

**I decline to complete this form.**

**Date:** \_\_\_\_\_

Parent/Guardian Information									
Parent/Guardian Name Last First Middle					Home Phone ( )				
Primary Address Street City State Zip Code					Cell Phone. ( )				
Are you or any member of your immediate family in the military? <input type="checkbox"/> Yes <input type="checkbox"/> No Names of those serving _____					Work Phone ( )				
e-Mail Address			Do we have your permission to email information to you? <input type="checkbox"/> Yes <input type="checkbox"/> No			Are you looking for outside referrals to assist you and your family today? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Language Preference		Name of Emergency Contact for your child other than you				Phone Number			
Parent/Guardian Name Last First Middle			Language Preference			Home Phone ( )			
Primary Address Street City State Zip Code					Cell Phone. ( )				
e-Mail Address			Do we have your permission to email or text information to you? <input type="checkbox"/> Yes <input type="checkbox"/> No			Work Phone ( )			
Child's Information									
Childs Name Last First Middle					Age		Date of Birth / /		
Language Preference		What name does your child prefer (nickname)			Please list any allergies or disabilities we should be aware of				
Childs Name Last First Middle			Age			Date of Birth / /			
Language Preference		What name does your child prefer (nickname)			Please list any allergies or disabilities we should be aware of				
Childs Name Last First Middle			Age			Date of Birth / /			
Language Preference		What name does your child prefer (nickname)			Please list any allergies or disabilities we should be aware of				
Childs Name Last First Middle			Age			Date of Birth / /			
Language Preference		What name does your child prefer (nickname)			Please list any allergies or disabilities we should be aware of				
For Office Use Only									
Officer Name/Report#				Phone ( )		Alleged Offender's Name(s)			
DCFS Name/Report#				Phone ( )		Electronics <input type="checkbox"/> Cell <input type="checkbox"/> Computer <input type="checkbox"/> Tablet			
Advocate	ASA	Interviewer	Referred to MH _____ Adults _____ Children <input type="checkbox"/> No			Medical <input type="checkbox"/> ER <input type="checkbox"/> SANE <input type="checkbox"/> _____			Mitch

**For Internal Use Only**