TAHOE YOUTH & FAMILY SERVICES

A SAFETY NET OF SERVICES FOR YOUTH AND FAMILIES

Dear Client,

Thank you for your interest in Tahoe Youth & Family Services. We hope that the following information will help you complete this intake packet.

Tahoe Youth & Family Services believes that the family plays a significant role in the success of every family member's development and experience with our agency. Below are some tips to help you with the intake packet as well as the counseling experience.

- If a minor is the primary client, the only paperwork that is NOT to be filled out by, or about, the minor is the questionnaire marked "Parent/Guardian Questionnaire" on the top right corner.
- Please be on time for your scheduled appointment. **We require a 24-hour notice of cancellation** so that we may plan accordingly. Tahoe Youth & Family Services' policy is to discharge clients after 2 cancellations without prior notice.
- **Please bring only those children being seen for your scheduled appointment.** You will find that our lobby is not conducive to waiting with young children for an hour.
- Please be aware that TYFS accepts credit/debit cards and cash (exact change) only.

We truly hope that you find your experience with Tahoe Youth & Family Services to be helpful and positive.
Should you have any concerns or questions, please do not hesitate to ask.
Information provided on the questionnaire is confidential unless it is dangerous to self or others.

Thank you for choosing Tahoe Youth & Family Services.

Tahoe Youth and Family Services Offices and Drop In Center Locations

Gardnerville Office
1512 Hwy 395, Suite 3
Gardnerville, NV 89410
Ph (775) 782-4202
Fax (775) 782-5055

Gardnerville Drop In Center
1307 Langley, Unit 1
Gardnerville, NV 89460

South Lake Tahoe Office & Drop In Center
1021 Fremont Ave.
South Lake Tahoe, CA 96150
Ph (530) 541-2445
Fax (530) 541-0517

Alpine County Office
Early Learning Center
100 Foothill Rd., Bld. D, Room 5
Woodfords, CA 96120
Ph (530) 694-9459

Text 'tahoeyouth' to 839-863 ● Crisis Line (800) 870-8937
www.tahoeyouth.org

CONFIDENTIAL MEDICAL HISTORY

(Babies & Young Children 0-9 years)

To be filled out by the parent/guardian.

Client # Office Use Only: ________

Client Name: ______________________________ Sex: ❑ M ❑ F Age: ____ Date of Birth: _____ /_____ /____

Place of Birth: ___________________________________ Social Security #: ____________________________

Does your child have medical insurance? ❑ Yes ❑ No

If "yes" please provide copy of the card, & who is your carrier? ______________________________________

Current State of Child's Health: ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Was child premature? ❑ Yes ❑ No *If yes, how many weeks?* _______________

With whom does the child live?

Name: ___________________________________ **Relationship:** _____________________________

Address: ____

Street City State Zip

Mailing Address: ____

Street/P.O. Box City State Zip

Home Phone: (________) _________ -- ____________ **Cell Phone: (_______) _________ -- ____________**

Can we leave a message? Home ❑ Cell ❑ **Ethnicity/Race:** __________________________________

Marital Status: ❑ **Single** ❑ **Married** ❑ **Divorced** ❑ **Partner** ❑ **Widowed**

Occupation: ________________________________ **Disability:** ____________________________

Who else lives in your child's home?

NAME	**AGE**	**DOB**	**DISABILITY**

Sisters:

____

____

____

Brothers:

____

____

____

(continued…)

Roommates:

____
____

Other: ____

Please check below any health problems your child has or has had, past or present.

❑ Nervousness/Anxiety ❑ Insomnia ❑ Depression

Please indicate any psychiatric/psychological treatment:

❑ None

❑ Outpatient (Date: _____ /_____ /_____) Where: _________________________________

❑ Inpatient (Date: _____ /_____ /_____) Where: _________________________________

Please list any hospitalizations (including psychiatric):

AGE	ILLNESS/INJURY/OPERATION	OUTCOME
______	____	_______________________
______	____	_______________________
______	____	_______________________

Has your child had any suicide attempts? ❑ Yes ❑ No
Any attempts without hospitalization? ❑ Yes ❑ No

If "yes", please explain: ____
____

Has your child ever had problems with eating or weight, such as bulimia, anorexia?
Over-eating, or not eating? ❑ Yes ❑ No

Has your child had any history of cutting or self-mutilation? ❑ Yes ❑ No

Has your child been molested or assaulted? ❑ Yes ❑ No

Were they treated by a physician? ❑ Yes ❑ No

If "yes", when? _____ /_____ /_____

Please indicate any past or current health problems below. If none, leave blank.

PROBLEM/SYMPTOM	AGE	P=PAST/ C=CURRENT	PROBLEM/SYMPTOM	AGE	P=PAST/ C=CURRENT
Tonsils out	_____	_____	Dental Problems	_____	_____
Allergies/Asthma	_____	_____	Eating Disorders	_____	_____
Emphysema	_____	_____	Frequent Headaches	_____	_____
Bronchitis	_____	_____	Depression/Suicidal Thoughts	_____	_____
Pneumonia	_____	_____			
Tuberculosis	_____	_____	Excessive Fatigue	_____	_____
Anemia	_____	_____	Persistent Diarrhea (for weeks or months)	_____	_____
Blood Clotting	_____	_____			
High Blood Pressure	_____	_____	Kidney/Bladder Trouble	_____	_____
Heart Trouble	_____	_____	Polio	_____	_____
Diabetes	_____	_____	Rheumatic Fever	_____	_____
Cancer or Tumor	_____	_____	Malaria	_____	_____
Epilepsy	_____	_____	Mononucleosis	_____	_____
Yellow Jaundice	_____	_____	Encephalitis	_____	_____
Ulcers	_____	_____	Meningitis	_____	_____
Arthritis/Gout	_____	_____	Skin Problems	_____	_____
Thyroid Disease	_____	_____	Persistent White Spots or Blemishes in the Mouth	_____	_____
Liver Disease	_____	_____			
Chicken Pox	_____	_____			
Measles	_____	_____	Unexplained Excessive Weight Loss	_____	_____
Mumps	_____	_____			
Ear aches	_____	_____	Hyperactivity	_____	_____
Vision Problems	_____	_____	Accident Prone	_____	_____
Hearing Problems	_____	_____	Head Injuries	_____	_____

Other: ____

Please give details on any "yes" responses: ______________________________________

____

Is your child currently taking any medications? If "yes", please list:

MEDICATION	TAKEN FOR
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

Has your child ever taken any medications for moods (depression, anxiety) or behavior (hyperactivity), such as Paxil, Prozac, Zoloft, Ritalin, etc.? ❑ Yes ❑ No ❑ Not Sure

If "yes", please list: ____

Is anyone in your immediate family taking any of these medications? ❑ Yes ❑ No ❑ Not Sure

If "yes", who, and what is s/he taking? ____

How many caffeinated beverages (sodas, coffee, tea, iced tea) does your child drink per day?

____

Are your child's immunizations (vaccines) up to date? ❑ Yes ❑ No ❑ Not Sure

Date of last tetanus shot: _____ /_____ /_____

Does your child have any current medical problems that may interfere with his/her participation in counseling?
❑ Yes ❑ No

If "yes", please explain: ____

____

____

Where does your child obtain medical services? ❑ Health Department ❑ Private Physician

Who is your child's doctor? ____

____

____

____

PARENT/GUARDIAN QUESTIONNAIRE
(Babies & Young Children 0-9 years)

Today's Date: _______ /_______ /_______

Client # Office Use Only: _______________

Client (Child's) Name:________________________________ **Age:** _________

School Name: ______________________________________**School Grade:**________**Date of Birth:** ______/______/______

PLEASE CIRCLE ONE: Parent / Guardian / Step / Foster

Mother's Name: ____**Age:** ________**DOB**_____/_____/______

Address: ____
Street City State Zip

Mailing Address:____
Street/P.O. Box City State Zip

Home Phone: (_________) __________ -- ______________ **Cell Phone:** (________) __________ -- ______________

Can we leave a message? **Home** ❑ **Cell** ❑ **Ethnicity/Race:** _____________________________________

Marital Status: ❑ **Single** ❑ **Married** ❑ **Divorced** ❑ **Partner** ❑ **Widowed**

Occupation: __________________________________ **Disability:** ____________________________

PLEASE CIRCLE ONE: Parent / Guardian / Step / Foster

Father's Name: ____**Age:** _______________**DOB**_____/______/_____

Address: ____
Street City State Zip

Mailing Address:____
Street/P.O. Box City State Zip

Home Phone: (_________) __________ -- ______________ **Cell Phone:** (________) __________ -- ________________

Can we leave a message? **Home** ❑ **Cell** ❑ **Ethnicity/Race:** _______________________________________

Marital Status: ❑ **Single** ❑ **Married** ❑ **Divorced** ❑ **Partner** ❑ **Widowed**

Occupation: __________________________________ **Disability:** ______________________________

<u>The following questions will allow us to find out more about the problems you are dealing with. By giving these questions your full attention, you will help us better assist you, and it will help you to clarify the problems you want to work on.</u>

(If you do not have enough space for an answer, please continue in the space provided on page 11)

Please list some of the problems you are encountering being a parent.

____

____

____

What are some of the current behaviors of your child (or children) that concern you the most?

____

____

____

In what ways, have you tried to solve these problems on your own?

____

____

____

What past events do you feel may have contributed to the current problems/concerns?

____

____

____

Please list three goals you would like to accomplish for you, your child, or your family.

1. ____

2. ____

3. ____

Specifically, what do you feel we can do to help you and your child/children accomplish these goals?

____

____

____

____

Please check all the behaviors or symptoms that you believe your child has experienced.

- ❑ Cries a lot
- ❑ Can't be calmed or soothed
- ❑ Sleep problems
- ❑ Wanders at night
- ❑ Talks or cries in sleep
- ❑ Shy
- ❑ Difficulty with change
- ❑ Withdrawn
- ❑ Fearful or anxious
- ❑ Sick frequently
- ❑ Rocking
- ❑ Head banging
- ❑ Clingy and inappropriately demanding
- ❑ Avoids looking others in the eye
- ❑ Short attention span
- ❑ Daydreams or get lost in thought, stares into space
- ❑ Can't stand having things out of place
- ❑ Can't stand waiting, wants everything now
- ❑ Eating problems (hoarding or picky eater)
- ❑ Fears certain animals, situations, or places other than daycare or school (describe)

  ____
- ❑ Easily frustrated
- ❑ Can't sit still or is restless
- ❑ Difficulty following directions
- ❑ Easily jealous
- ❑ Unmotivated, won't play alone
- ❑ Fearless
- ❑ Underactive, moves slowly or lack of energy
- ❑ Sudden changes in mood or feeling
- ❑ Vomiting (without medical cause)
- ❑ Behavior problems at school or daycare
- ❑ Difficulty getting along with others
- ❑ Disturbs other children
- ❑ Whining
- ❑ Impulse control
- ❑ Defies rules
- ❑ Difficulty with right and wrong
- ❑ Resists going to bed
- ❑ Acts too young for age
- ❑ Doesn't know how to have fun; acts like a "little adult"
- ❑ Hits others or bites, aggression to others
- ❑ Truant from school before age 13
- ❑ Overactive
- ❑ Temper tantrums
- ❑ Inappropriate sexual behavior
- ❑ Elimination problems (soiling pants, bed wetting)
- ❑ Preoccupation with fire, gore or evil
- ❑ Persistent nonsense questions and incessant chatter
- ❑ Speech problems
- ❑ Stealing
- ❑ Perceives self as victim (helpless)
- ❑ Destructive
- ❑ Self-mutilating
- ❑ Holds breath
- ❑ Cruel to animals
- ❑ Doesn't feel guilty after misbehaving
- ❑ Doesn't answer when people speak to them

Parent Observations: Please check the following:

		YES	NO
1.	The child reciprocates when smiling at them or saying hello?	❑	❑
2.	Will share play objects?	❑	❑
3.	Will take turns?	❑	❑
4.	Will engage in pretend play with others?	❑	❑
5.	Willingly follow the rules?	❑	❑
6.	Uses words or gestures to communicate needs or feelings?	❑	❑
7.	Shows curiosity about the environment (people & things) using words or gestures?	❑	❑
8.	Is comfortable with new experiences?	❑	❑
9.	Is comfortable when saying goodbye to caregiver?	❑	❑
10.	Is excited when you pick them up from sitter or continues playing?	❑	❑

Are you currently seeking services?

❑ *Private Therapist/Counselor Name:* __________________*Another Agency:* ___________

Who referred you here?

____

Have any of the following situations happened in your family? If so, when?

Situation	Year Occurred
❑ Parents' divorce	________________
❑ Custody battle, Is it current ❑ YES ❑ NO	________________
❑ Primary Custodial Parent Name: ________________	
❑ Death in the family or someone close	________________
❑ Hospitalization of child	________________
❑ Loss of friends	________________
❑ Death of pet	________________
❑ Significant person leaving	________________
❑ Move from location, house or school	________________
❑ Parents hospitalized	________________
❑ Parents incarcerated or left home	________________
❑ Major illness in family (mental or physical)	________________
❑ Witnessed a crime or a victim of one	________________
❑ Adoption	________________
❑ Foster Care Placement	________________
❑ Child has lived with friend or relative	________________

Has your child experienced any trauma or stressors? Check all that apply.

- ☐ Accident
- ☐ Severe illness
- ☐ Physical, sexual, or emotional abuse
- ☐ Homeless Past ☐ Present ☐
- ☐ Family member using drugs or alcohol Past ☐ Present ☐
- ☐ Frequent changes in child care
- ☐ Learning Disabilities (Has your child been tested? What was the treatment?)
- ☐ Separation from parents or primary caregiver

Please list any counselors, therapists, psychologists, psychiatrists, and doctors that you or your child has seen (evaluations, exams, testing).

Child	Dates of Services	Parent	Date of Services

Please use the space below for any additional thoughts or concerns you may have regarding your child/children.

____

____

____

____

____

____

____

T A H O E
YOUTH & FAMILY
S E R V I C E S
A SAFETY NET OF SERVICES FOR YOUTH AND FAMILIES

FEE DETERMINATION

Thank you for choosing Tahoe Youth & Family Services.

We ask that you provide important basic information to assess your situation and the appropriate funding source for your services. If we are unable to assist you, we will offer other appropriate referrals in the community.

Individual/Family sessions are 45-50 minutes. Group sessions are 80 minutes in California and 50 minutes in Nevada.

Services will not be provided, nor will verification of services be provided until all requested financial information is received, signed and processed. TYFS requires payment prior to the start of a session. Payments may be made directly to TYFS' Client Advocates.

Yes ❑ No ❑ CLIENT HAS HEALTH INSURANCE (MEDICAID, MEDI-CAL, PRIVATE INSURANCE: _________________)
Please provide a copy of the health insurance card & the social security number of the primary insured.
Co-Pay Required? Yes ❑ No ❑ Co-Pay Amount: Individual $ _________ Group $ __________
Co-Insurance? Yes ❑ No ❑ Co-Insurance Percentage: ___________%

Yes ❑ No ❑ CLIENT QUALIFIES FOR ANOTHER FUNDING SOURCE? (DRYS, SAPTA, TRYS, ______________)
Referral Required? Yes ❑ No ❑ Authorization needed? Yes ❑ No ❑

Yes ❑ No ❑ CLIENT WISHES TO PAY CASH FOR SERVICES (cash or card only, must be exact change)
$75 charge per individual session.

Yes ❑ No ❑ CLIENT IS REQUESTING A REPORT BE SENT TO THE COURT BASED ON THE FINDINGS OF A DRUG & ALCOHOL EVALUATION because of a DUI offense, court order, or any other reason; the charge is $100 and is due prior to scheduling the appointment for the evaluation.

Yes ❑ No ❑ CLIENT IS REQUESTING A REPORT BE SENT TO THE COURT BASED ON THE FINDINGS OF A MENTAL HEALTH EVALUATION because of a court order or any other reason; the charge is $100 and is due prior to scheduling the appointment for the evaluation.

Parent or Guardian Signature: ____ *Date:* __________________

TAHOE YOUTH & FAMILY SERVICES

A SAFETY NET OF SERVICES FOR YOUTH AND FAMILIES

Monday-Thursday 9a-5p

(closed for lunch from 12p to 1p)

(775) 782-4202 or (530) 541-2445

24-hour voicemail

NO-SHOW and/or LATE APPOINTMENT CANCELLATION POLICY

Please call the office at least 24 hours before your scheduled appointment to make a change or cancellation. Regardless of your fee determination, the following fees will be levied:

1. A fee of $50.00 will be assessed if I do not provide a minimum of 24 hours' notice when I need to cancel or change an appointment. ______ **(Please initial)**
2. A fee of $50.00 will be assessed if I arrive 15 minutes late or more after the scheduled appointment. ______ **(Please initial)**
3. A fee of $125.00 will be assessed if I miss an appointment without contacting the office to cancel the appointment. ______ **(Please initial)**
4. If I miss 2 sessions for unexcused reasons, I may be discharged from services at Tahoe Youth & Family Services' discretion. ______ **(Please initial)**

Please leave a message at ext. 100 if you are unable to reach a staff member by phone.

I understand that Tahoe Youth & Family Services is unable to contact me to remind me about appointments.
I will receive an appointment reminder card upon scheduling an appointment to serve as my reminder (unless the appointment is scheduled over the phone.) I understand that I am encouraged to contact Tahoe Youth & Family Services at any time if I need to verify an appointment date and/or time. I understand that if any of the above fees are assessed, my appointments will be removed from the calendar until the fee is paid. At the time of payment, my new appointment will be scheduled based on the current availability.
I understand that insurance companies cannot be billed for these fees therefore they are solely my responsibility.
By signing below, I agree to the above policy and stated fees.

Parent or Guardian Signature: ____ *Date:* __________________

TYFS Staff assisting client: ____ *Date:* __________________