



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***





**CLIENT (Youth 10-17 years)**  
**CONFIDENTIAL QUESTIONNAIRE**  
*To be filled out by the client (youth)*

Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Client # Office Use Only: \_\_\_\_\_

**PLEASE PRINT**

Client Name: \_\_\_\_\_ Sex:  M  F Age: \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Place of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
City State

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  Client's Ethnicity/Race: \_\_\_\_\_

Client Marital Status:  Single  Married  Divorced  Partner  Widowed

Disability: \_\_\_\_\_ School Name: \_\_\_\_\_ School Grade: \_\_\_\_\_

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

**If you do not live with any of the above, with whom do you 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 home?**

NAME AGE DOB DISABILITY

Sisters:

---

---

---

Brothers:

---

---

---

Roommates:

---

---

Other:

---

**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 (Who? \_\_\_\_\_ ) \_\_\_\_\_
  - Significant person leaving (Who? \_\_\_\_\_ ) \_\_\_\_\_
  - Arrest (Who? \_\_\_\_\_ ) \_\_\_\_\_
  - Accident or injury (Who? \_\_\_\_\_ ) \_\_\_\_\_
  - Physical or sexual assault \_\_\_\_\_
  - Major family illness (mental or physical) \_\_\_\_\_
  - Recent move \_\_\_\_\_
  - Parent in jail or prison (past\_\_\_\_ present\_\_\_\_) \_\_\_\_\_
  - Pregnancy, self or parent \_\_\_\_\_
  - Expulsion or suspension from school \_\_\_\_\_
  - Witnessing a crime or being a victim of one \_\_\_\_\_
  - Family member using drugs or alcohol (past \_\_\_\_ present\_\_\_\_) \_\_\_\_\_
  - Adoption or Foster services \_\_\_\_\_
  - Other: \_\_\_\_\_
  - Have you had a history of cutting or self-harm? Yes  No  \_\_\_\_\_
  - Have you had any suicide attempts? Yes  No  \_\_\_\_\_
  - Any attempts without hospitalization? Yes  No  \_\_\_\_\_
  - Do you have any relatives that have had serious mental or emotional problems? Yes  No
- If "yes", please list them:
- \_\_\_\_\_
- \_\_\_\_\_

**Are you currently seeking services?**

- Private Therapist/Counselor Name: \_\_\_\_\_
- Another Agency: \_\_\_\_\_

**Who referred you here?**

- Self
- Another Agency: \_\_\_\_\_

Has anyone felt concerned about your drinking or using? Yes  No   
 Do you feel concerned about your use? Yes  No   
 Do most of your friends use or drink? Yes  No   
 Have you ever overdosed on drugs or alcohol (alcohol poisoning)? Yes  No   
 Have you ever been to the emergency room or hospital? Yes  No   
 Has alcohol or drug use caused problems for you at school, at home, in relationships, or at your job? Yes  No

If yes, please explain: \_\_\_\_\_

Have you ever used drugs to numb uncomfortable feelings? Yes  No   
 (boredom, sadness, anxiety, insomnia/sleeplessness)  
 Have you ever received outpatient treatment for drugs or alcohol use? Yes  No   
 If yes, when and where? (includes TYFS outpatient, Juvenile Hall or other agency)

Has any family member received treatment for drug(s) or alcohol use? Yes  No

If yes, when and where? \_\_\_\_\_

Have you ever been under the influence of drugs or alcohol?  Yes  No

**Have you ever used any of the following? Please be honest.**

**THIS IS CONFIDENTIAL**

<b>Alcohol</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	How many times? _____	Age first tried: _____
<b>Marijuana</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	How many times? _____	Age first tried: _____
<b>Spice</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	How many times? _____	Age first tried: _____
<b>Hallucinogens (LSD, mushrooms, etc.)</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	How many times? _____	Age first tried: _____
<b>Cocaine</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	How many times? _____	Age first tried: _____
<b>Crack (Ice)</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	How many times? _____	Age first tried: _____
<b>Methamphetamines (crank, speed)</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	How many times? _____	Age first tried: _____
<b>Ecstasy (E)</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	How many times? _____	Age first tried: _____
<b>Pills (codeine, oxycotin, vicodin, soma, valium, xanax, etc.)</b>				
	Yes <input type="checkbox"/>	No <input type="checkbox"/>	How many times? _____	Age first tried: _____
<b>Inhalants, nitrous oxide</b>				
	Yes <input type="checkbox"/>	No <input type="checkbox"/>	How many times? _____	Age first tried: _____
<b>Heroin, morphine, methadone</b>				
	Yes <input type="checkbox"/>	No <input type="checkbox"/>	How many times? _____	Age first tried: _____
<b>Over the counter medication</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	How many times? _____	Age first tried: _____
<b>Do you regularly smoke cigarettes?</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	How much/how often? _____	Age first tried: _____
<b>Would you like help to quit?</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>		

**Please check all the behaviors or symptoms that you have experienced.**

<b>Now</b>	<b>Past</b>		<b>Now</b>	<b>Past</b>	
<input type="checkbox"/>	<input type="checkbox"/>	Lack of energy	<input type="checkbox"/>	<input type="checkbox"/>	Sneaking out & staying out all night before the age of 13
<input type="checkbox"/>	<input type="checkbox"/>	Feelings of sadness or depression	<input type="checkbox"/>	<input type="checkbox"/>	Running away (how many times? _____)
<input type="checkbox"/>	<input type="checkbox"/>	Irritability	<input type="checkbox"/>	<input type="checkbox"/>	Truant from school before age 13
<input type="checkbox"/>	<input type="checkbox"/>	Trouble sleeping	<input type="checkbox"/>	<input type="checkbox"/>	Expressing severe disgust in others
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty concentrating	<input type="checkbox"/>	<input type="checkbox"/>	Having nightmares or flashbacks about being abused
<input type="checkbox"/>	<input type="checkbox"/>	Changes in eating patterns	<input type="checkbox"/>	<input type="checkbox"/>	Increase in aggressive behavior
<input type="checkbox"/>	<input type="checkbox"/>	Low self-esteem	<input type="checkbox"/>	<input type="checkbox"/>	Major increase or decrease in interest in sex
<input type="checkbox"/>	<input type="checkbox"/>	Feelings of hopelessness or guilt	<input type="checkbox"/>	<input type="checkbox"/>	Anger, rage or fear towards certain people
<input type="checkbox"/>	<input type="checkbox"/>	Thoughts of suicide	<input type="checkbox"/>	<input type="checkbox"/>	Thumb sucking
<input type="checkbox"/>	<input type="checkbox"/>	Lack of caring about anything	<input type="checkbox"/>	<input type="checkbox"/>	Baby talk
<input type="checkbox"/>	<input type="checkbox"/>	Isolation and/or trouble making or keeping friends	<input type="checkbox"/>	<input type="checkbox"/>	Bed wetting
<input type="checkbox"/>	<input type="checkbox"/>	Suicide attempt If yes, when _____	<input type="checkbox"/>	<input type="checkbox"/>	Problems with parent(s)
<input type="checkbox"/>	<input type="checkbox"/>	Feeling restless or nervous	<input type="checkbox"/>	<input type="checkbox"/>	Problems with sibling(s)
<input type="checkbox"/>	<input type="checkbox"/>	Having racing thoughts	<input type="checkbox"/>	<input type="checkbox"/>	Problems with other significant person
<input type="checkbox"/>	<input type="checkbox"/>	Excessive worrying	<input type="checkbox"/>	<input type="checkbox"/>	Academic problems
<input type="checkbox"/>	<input type="checkbox"/>	Confused thinking or mind "going blank"	<input type="checkbox"/>	<input type="checkbox"/>	Attraction to the same sex
<input type="checkbox"/>	<input type="checkbox"/>	Avoiding certain situations or people	<input type="checkbox"/>	<input type="checkbox"/>	Problems adapting from old culture to new
<input type="checkbox"/>	<input type="checkbox"/>	Panic attacks	<input type="checkbox"/>	<input type="checkbox"/>	Mood swings
<input type="checkbox"/>	<input type="checkbox"/>	Poor body image	<input type="checkbox"/>	<input type="checkbox"/>	Change in friends
<input type="checkbox"/>	<input type="checkbox"/>	Perfectionism	<input type="checkbox"/>	<input type="checkbox"/>	Drop in grades and/or extended absences or tardiness
<input type="checkbox"/>	<input type="checkbox"/>	Eating very little or fasting	<input type="checkbox"/>	<input type="checkbox"/>	Poor self-image ("I'm a loser")
<input type="checkbox"/>	<input type="checkbox"/>	Exercising frequently	<input type="checkbox"/>	<input type="checkbox"/>	Low energy, sleeping more
<input type="checkbox"/>	<input type="checkbox"/>	Overeating	<input type="checkbox"/>	<input type="checkbox"/>	Withdrawal from family and close friends
<input type="checkbox"/>	<input type="checkbox"/>	Vomiting after eating	<input type="checkbox"/>	<input type="checkbox"/>	Hearing voices when not under the influence of drugs or alcohol
<input type="checkbox"/>	<input type="checkbox"/>	Dental problems	<input type="checkbox"/>	<input type="checkbox"/>	Hallucinations when not under the influence of drugs or alcohol
<input type="checkbox"/>	<input type="checkbox"/>	Being "hyper"	<input type="checkbox"/>	<input type="checkbox"/>	Head injury (Date: ____/____/____)
<input type="checkbox"/>	<input type="checkbox"/>	Having difficulty paying attention	<input type="checkbox"/>	<input type="checkbox"/>	Sexual abuse
<input type="checkbox"/>	<input type="checkbox"/>	Being fidgety or restless	<input type="checkbox"/>	<input type="checkbox"/>	Physical abuse
<input type="checkbox"/>	<input type="checkbox"/>	Reading or learning disability	<input type="checkbox"/>	<input type="checkbox"/>	Emotional abuse
<input type="checkbox"/>	<input type="checkbox"/>	Problems getting along with others	<input type="checkbox"/>	<input type="checkbox"/>	Witnessed or experienced traumatic event (car crash, earthquake, etc.)
<input type="checkbox"/>	<input type="checkbox"/>	Losing temper often	<input type="checkbox"/>	<input type="checkbox"/>	Nightmares
<input type="checkbox"/>	<input type="checkbox"/>	Arguing with adults and/or refusing to obey authority figures	<input type="checkbox"/>	<input type="checkbox"/>	Feeling numb or detached ("in a daze" or "out of it")
<input type="checkbox"/>	<input type="checkbox"/>	Blaming others for your mistakes	<input type="checkbox"/>	<input type="checkbox"/>	Irritable
<input type="checkbox"/>	<input type="checkbox"/>	Being overly sensitive, "touchy", vindictive	<input type="checkbox"/>	<input type="checkbox"/>	Unable to remember or recall certain events
<input type="checkbox"/>	<input type="checkbox"/>	Initiating fights	<input type="checkbox"/>	<input type="checkbox"/>	Having access to guns or weapons
<input type="checkbox"/>	<input type="checkbox"/>	Being cruel to animals or people	<input type="checkbox"/>	<input type="checkbox"/>	Stealing things
<input type="checkbox"/>	<input type="checkbox"/>	Deliberately setting fire to or destroying other's property	<input type="checkbox"/>	<input type="checkbox"/>	Lying, manipulating, or "conning"







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

**PARENT/GUARDIAN (Youth 10-17 years)**  
**CONFIDENTIAL QUESTIONNAIRE**  
*To be filled out by the Parent/Guardian*

Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**PLEASE PRINT**

Client's (Child's) Name: \_\_\_\_\_ Sex:  M  F Age: \_\_\_\_\_

DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Social Security # \_\_\_\_\_ Insurance: \_\_\_\_\_

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

**The following 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 issues you want to work on.**

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?

---

---

---

---

---

---

---

**Are you currently seeking services?**

- Private Therapist/Counselor Name: \_\_\_\_\_
- Another Agency: \_\_\_\_\_

**Who referred you here?**

- Self
- Another Agency: \_\_\_\_\_

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

Child	Dates of Services	Parent	Dates of Services

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

- Parents' divorce \_\_\_\_\_
- Custody battle, Is it current  YES  NO \_\_\_\_\_
- Primary Custodial Parent Name: \_\_\_\_\_
- Death in the family (Who? \_\_\_\_\_ ) \_\_\_\_\_
- Significant person leaving (Who? \_\_\_\_\_ ) \_\_\_\_\_
- Arrest (Who? \_\_\_\_\_ ) \_\_\_\_\_
- Accident or injury (Who? \_\_\_\_\_ ) \_\_\_\_\_
- Physical or sexual assault \_\_\_\_\_
- Major family illness (mental or physical) \_\_\_\_\_
- Recent move \_\_\_\_\_
- Family member in jail or prison (past \_\_\_\_ present \_\_\_\_ ) \_\_\_\_\_
- Pregnancy, self or parent \_\_\_\_\_
- Expulsion or suspension from school \_\_\_\_\_
- Witnessing a crime or being a victim of one \_\_\_\_\_
- Family member using drugs or alcohol (past \_\_\_\_ present \_\_\_\_ ) \_\_\_\_\_
- Adoption or Foster services \_\_\_\_\_
- Other: \_\_\_\_\_
- Have you had a history of cutting or self-harm? Yes  No  \_\_\_\_\_
- Have you had any suicide attempts? Yes  No  \_\_\_\_\_
- Any attempts without hospitalization? Yes  No  \_\_\_\_\_
- Do you have any relatives that have had serious mental or emotional problems? Yes  No

If "yes", please list them: \_\_\_\_\_

**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 Past  Present
  - Learning disabilities Past  Present  Has your child been tested?  Yes  No
- What was the treatment? \_\_\_\_\_

Separation from parents or primary caregiver

Does your child have a history of cutting, or other self-harm?  Yes  No

Has your child had any suicide attempts?  Yes  No Dates: \_\_\_\_\_

Any attempts without hospitalization?  Yes  No Dates: \_\_\_\_\_

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

<b>Now</b>	<b>Past</b>		<b>Now</b>	<b>Past</b>	
<input type="checkbox"/>	<input type="checkbox"/>	Lack of energy	<input type="checkbox"/>	<input type="checkbox"/>	Sneaking out & staying out all night before the age of 13
<input type="checkbox"/>	<input type="checkbox"/>	Feelings of sadness or depression	<input type="checkbox"/>	<input type="checkbox"/>	Running away (how many times? _____)
<input type="checkbox"/>	<input type="checkbox"/>	Irritability	<input type="checkbox"/>	<input type="checkbox"/>	Truant from school before age 13
<input type="checkbox"/>	<input type="checkbox"/>	Trouble sleeping	<input type="checkbox"/>	<input type="checkbox"/>	Expresses severe disgust in others
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty concentrating	<input type="checkbox"/>	<input type="checkbox"/>	Has nightmares or flashbacks about being abused
<input type="checkbox"/>	<input type="checkbox"/>	Changes in eating patterns	<input type="checkbox"/>	<input type="checkbox"/>	Increase in aggressive behavior
<input type="checkbox"/>	<input type="checkbox"/>	Low self-esteem	<input type="checkbox"/>	<input type="checkbox"/>	Major increase or decrease in interest in sex
<input type="checkbox"/>	<input type="checkbox"/>	Feelings of hopelessness or guilt	<input type="checkbox"/>	<input type="checkbox"/>	Anger, rage or fear towards certain people
<input type="checkbox"/>	<input type="checkbox"/>	Thoughts of suicide	<input type="checkbox"/>	<input type="checkbox"/>	Thumb sucking
<input type="checkbox"/>	<input type="checkbox"/>	Lack of caring about anything	<input type="checkbox"/>	<input type="checkbox"/>	Baby talk
<input type="checkbox"/>	<input type="checkbox"/>	Isolation and/or trouble making or keeping friends	<input type="checkbox"/>	<input type="checkbox"/>	Bed wetting
<input type="checkbox"/>	<input type="checkbox"/>	Suicide attempt	<input type="checkbox"/>	<input type="checkbox"/>	Problems with parent(s)
<input type="checkbox"/>	<input type="checkbox"/>	Feeling restless or nervous	<input type="checkbox"/>	<input type="checkbox"/>	Problems with sibling(s)
<input type="checkbox"/>	<input type="checkbox"/>	Having racing thoughts	<input type="checkbox"/>	<input type="checkbox"/>	Problems with other significant person Who? _____
<input type="checkbox"/>	<input type="checkbox"/>	Excessive worrying	<input type="checkbox"/>	<input type="checkbox"/>	Academic problems
<input type="checkbox"/>	<input type="checkbox"/>	Confused thinking or mind "going blank"	<input type="checkbox"/>	<input type="checkbox"/>	Attraction to the same sex
<input type="checkbox"/>	<input type="checkbox"/>	Avoiding certain situations or people	<input type="checkbox"/>	<input type="checkbox"/>	Problems adapting from old culture to new
<input type="checkbox"/>	<input type="checkbox"/>	Panic attacks	<input type="checkbox"/>	<input type="checkbox"/>	Mood swings
<input type="checkbox"/>	<input type="checkbox"/>	Poor body image	<input type="checkbox"/>	<input type="checkbox"/>	Change in friends
<input type="checkbox"/>	<input type="checkbox"/>	Perfectionism	<input type="checkbox"/>	<input type="checkbox"/>	Drop in grades and/or extended absences or tardiness
<input type="checkbox"/>	<input type="checkbox"/>	Eating very little or fasting	<input type="checkbox"/>	<input type="checkbox"/>	Poor self-image ("I'm a loser")
<input type="checkbox"/>	<input type="checkbox"/>	Exercising frequently	<input type="checkbox"/>	<input type="checkbox"/>	Low energy, sleeping more
<b>Now</b>	<b>Past</b>		<b>Now</b>	<b>Past</b>	
<input type="checkbox"/>	<input type="checkbox"/>	Overeating	<input type="checkbox"/>	<input type="checkbox"/>	Withdrawal from family and close friends
<input type="checkbox"/>	<input type="checkbox"/>	Vomiting after eating	<input type="checkbox"/>	<input type="checkbox"/>	Hearing voices when not under the influence of drugs or alcohol
<input type="checkbox"/>	<input type="checkbox"/>	Dental problems	<input type="checkbox"/>	<input type="checkbox"/>	Hallucinations when not under the influence of drugs or alcohol
<input type="checkbox"/>	<input type="checkbox"/>	Being "hyper"	<input type="checkbox"/>	<input type="checkbox"/>	Head injury (Date: ____/____/____)
<input type="checkbox"/>	<input type="checkbox"/>	Having difficulty paying attention	<input type="checkbox"/>	<input type="checkbox"/>	Sexual abuse
<input type="checkbox"/>	<input type="checkbox"/>	Being fidgety or restless	<input type="checkbox"/>	<input type="checkbox"/>	Physical abuse
<input type="checkbox"/>	<input type="checkbox"/>	Reading or learning disability	<input type="checkbox"/>	<input type="checkbox"/>	Emotional abuse
<input type="checkbox"/>	<input type="checkbox"/>	Problems getting along with others	<input type="checkbox"/>	<input type="checkbox"/>	Witnessed or experienced traumatic event (car crash, earthquake, etc.)
<input type="checkbox"/>	<input type="checkbox"/>	Losing temper often	<input type="checkbox"/>	<input type="checkbox"/>	Nightmares
<input type="checkbox"/>	<input type="checkbox"/>	Arguing with adults and/or refusing to obey authority figures	<input type="checkbox"/>	<input type="checkbox"/>	Feeling numb or detached ("in a daze" or "out of it")
<input type="checkbox"/>	<input type="checkbox"/>	Often blaming others for his/her mistakes	<input type="checkbox"/>	<input type="checkbox"/>	Irritable
<input type="checkbox"/>	<input type="checkbox"/>	Overly sensitive, "touchy", vindictive	<input type="checkbox"/>	<input type="checkbox"/>	Unable to remember or recall certain events
<input type="checkbox"/>	<input type="checkbox"/>	Initiates fights	<input type="checkbox"/>	<input type="checkbox"/>	Has access to guns or weapons





**FEE DETERMINATION**

Thank you for choosing Tahoe Youth & Family Services.

We ask that you provide important basic information in order 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:** \_\_\_\_\_







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