CHILDREN 0-9

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

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

Crisis Line (800) 870-8937
www.tahoeyouth.org

TAHOE YOUTH & FAMILY SERVICES
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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:

_____
_____
_____

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? ❑ Yes ❑ No
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 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? _____

_____

_____

_____

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 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:** _____

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.

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

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
- ❑ Overactive
- ❑ Temper tantrums
- ❑ 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
- ❑ 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 <u>you</u> currently seeking services elsewhere?

Therapist/Counselor Name: _____Another Agency: _____

Who referred you here?_____

<u>Have any of the following situations happened in your family? If so, when?</u>

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	_____

<u>Has your child experienced any trauma or stressors? Check all that apply.</u>

❑ 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

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 find 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.
Intensive Outpatient Program Groups sessions are 180 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 each session.

Yes ❑ No ❑ CLIENT HAS HEALTH INSURANCE (MEDICAID, MEDI-CAL, PRIVATE INSURANCE: _____)
(Please provide a copy of the health insurance card & complete the insurance form on the back.)
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? (TRYS, OC, _____)
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)
NOT INCLUDING the Intensive Outpatient Program
$125.00 charge for the 1st appt; $95.00 charge per individual sessions; $30.00 charge per group sessions.
❑ **Session packages – 10 Individual Sessions for $900.00 OR 10 Group Sessions for $250.00**

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, MUST have a copy of the court order, the charge is $100.00 and is due prior to scheduling.

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 $315.00 for 3-sessions. Payment of $157.50 (half of full payment) is also accepted prior to scheduling.

Yes ❑ No ❑ INTENSIVE OUTPATIENT PROGRAM (requires 4 individual sessions and 12 group sessions per month)
$1,490.00 a month; or $395.00 1st week; $365.00 2nd 3rd and 4th week.
$125.00 for the 1st appt; $90.00 per group; $95.00 for individual.
❑ **Discount- If paid upfront 25% off = $1,117.50 and is due prior to scheduling.**

Signature: _____ Date: _____

TAHOE YOUTH & FAMILY SERVICES
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Insurance Information

CLIENT INFORMATION

PLEASE PRINT CLEARLY

Name: _____ Marital Status: □ Single □ Married □ Divorced □ Widowed □ Separated

Address: _____ Race/Ethnicity:_____

City: _____ State: _____ Zip: _____ 1st Language: □English □Spanish □ Other_____

Date of Birth _____ Check if minor □ (less than 18) Gender: □ M □ F 2nd Language: □English □Spanish □ Other_____

Soc. Sec. # _____

Home Phone: _____ Cell Phone: _____ Can we leave a message? Home □ Cell □

Employer: _____ Work Phone:_____

Referring Agency_____ Referring Agency Phone: _____

PARENT/GUARDIAN INFORMATION

Name: _____ Marital Status: □ Single □ Married □ Divorced □ Widowed □ Separated

Address: _____ Race/Ethnicity:_____

City: _____ State: _____ Zip: _____

Date of Birth _____ Gender: □ M □ F 1st Language: □English □Spanish □ Other_____

Soc. Sec. # _____ 2nd Language: □English □Spanish □ Other_____

Home Phone: _____ Cell Phone: _____ Can we leave a message? Home □ Cell □

Employer: _____ Work Phone: _____

INSURANCE INFORMATION

Primary Insurance Company: _____ Plan Phone: _____

Name of Person Insured: _____ Policyholder's DOB _____ Gender: □ M □ F

Soc Sec # _____Employer: _____ Patient Relationship: □Self □Child □Stepchild □Spouse □Other_____

Claims Address: _____ City: _____ State: _____ Zip: _____

Policy ID# _____ Group # _____ Group Name _____

Type of Coverage: □Group □Individual □ Is this a Retiree Plan? □ Yes □ No

Secondary Insurance Company: _____ Plan Phone: _____

Name of Person Insured: _____ Policyholder's DOB _____ Gender: □ M □ F

Soc Sec # _____ Employer: _____ Patient Relationship: □Self □Child □Stepchild □Spouse □Other_____

Claims Address: _____ City: _____ State: _____ Zip: _____

Policy ID# _____ Group # _____ Group Name _____

ASSIGNMENT OF BENEFITS

I hereby authorize payment directly to Tahoe Youth & Family Services (TYFS) of all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, and for all services rendered for me or for my dependents. TYFS will estimate your copay as accurately as possible based on your insurance plan. Your actual share of cost will be determined by your insurance Explanation of Benefits. I authorize TYFS, the therapist and or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of my signature on all insurance submissions. I authorize a copy of this document to be used in place of the original. I have read and agreed to the above.
Rev 10.2017

X_____Date:_____

Signature of Patient (If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above and fill in the information below.

Parent/Guardian Name (Print) _____ Relationship to Patient _____

TAHOE YOUTH & FAMILY SERVICES
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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.

Signature: _____ ***Date:*** _____

TYFS Staff assisting client: _____ ***Date:*** _____