



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 pages marked "To be filled out by Parent/Guardian".**
- 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***



BABIES & YOUNG CHILDREN (0-9 years)
CONFIDENTIAL QUESTIONNAIRE

To be filled out by the parent/guardian.

Date: _____

Client # (Office Use Only): _____

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

Physical address: _____

Place of Birth: _____ Social Security #: _____

School Name: _____ Grade: _____

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

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

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? YES NO **Ethnicity/Race:** _____

Marital Status: Single Married Divorced Partner Widowed

Occupation: _____ **Email Address:** _____

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? YES NO **Ethnicity/Race:** _____

Marital Status: Single Married Divorced Partner Widowed

Occupation: _____ **Email Address:** _____

Who else lives in your home?
(Names and ages)

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 | _____ | _____ | Excessive Fatigue | _____ | _____ |
| Tuberculosis | _____ | _____ | Persistent Diarrhea (for weeks or months) | _____ | _____ |
| Anemia | _____ | _____ | Kidney/Bladder Trouble | _____ | _____ |
| Blood Clotting | _____ | _____ | Polio | _____ | _____ |
| High Blood Pressure | _____ | _____ | Rheumatic Fever | _____ | _____ |
| Heart Trouble | _____ | _____ | Malaria | _____ | _____ |
| Diabetes | _____ | _____ | Mononucleosis | _____ | _____ |
| Cancer or Tumor | _____ | _____ | Encephalitis | _____ | _____ |
| Epilepsy | _____ | _____ | Meningitis | _____ | _____ |
| Yellow Jaundice | _____ | _____ | Skin Problems | _____ | _____ |
| Ulcers | _____ | _____ | Persistent White Spots or Blemishes in the Mouth | _____ | _____ |
| Arthritis/Gout | _____ | _____ | Unexplained Excessive Weight Loss | _____ | _____ |
| Thyroid Disease | _____ | _____ | Hyperactivity | _____ | _____ |
| Liver Disease | _____ | _____ | Accident Prone | _____ | _____ |
| Chicken Pox | _____ | _____ | Head Injuries | _____ | _____ |
| Measles | _____ | _____ | | | |
| Mumps | _____ | _____ | | | |
| Earaches | _____ | _____ | | | |
| Vision Problems | _____ | _____ | | | |
| Hearing Problems | _____ | _____ | | | |

Other: _____

Please give details on any "yes" responses: _____

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? _____

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

MEDICATION

TAKEN FOR

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? Clinic Private Physician

Who is your child's doctor? (Name, Address & Phone number)

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. _____

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

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:

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

Are you currently seeking services elsewhere? Yes or No , if yes please provide information

Therapist/Counselor or Agency Name: _____

Who referred you here? _____

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

| Situation | Year Occurred |
|---|----------------------|
| <input type="checkbox"/> Parents divorced | _____ |
| <input type="checkbox"/> Custody battle, Is it current <input type="checkbox"/> YES <input type="checkbox"/> NO | _____ |
| <input type="checkbox"/> Primary Custodial Parent Name: _____ | _____ |
| <input type="checkbox"/> Death in the family or someone close | _____ |
| <input type="checkbox"/> Hospitalization of child | _____ |
| <input type="checkbox"/> Loss of friends | _____ |
| <input type="checkbox"/> Death of pet | _____ |
| <input type="checkbox"/> Significant person leaving | _____ |
| <input type="checkbox"/> Move from a location, house or school | _____ |
| <input type="checkbox"/> Parent hospitalized | _____ |
| <input type="checkbox"/> Parent incarcerated or left the home | _____ |
| <input type="checkbox"/> Major illness in family (mental or physical) | _____ |
| <input type="checkbox"/> Witnessed a crime or a victim of one | _____ |
| <input type="checkbox"/> Adoption | _____ |
| <input type="checkbox"/> Foster Care Placement | _____ |
| <input type="checkbox"/> 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 childcare
- 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/or doctors that your child has seen (evaluations, exams, testing and dates of service).



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, you **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.

Parent/Guardian Signature: _____ Date: _____



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. Revised 11/18/2021 Page 10 of 11)

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



Monday-Thursday 9a-5p
(closed for lunch from 12p to 1p)
G'Ville(775) 782-4202 or SLT(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/Guardian Signature: _____ **Date:** _____

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