



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*

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

*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](http://www.tahoeyouth.org)***





**(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:

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Other: 

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**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.***

<b>PROBLEM/SYMPTOM</b>	<b>AGE</b>	<b>P=PAST/ C=CURRENT</b>	<b>PROBLEM/SYMPTOM</b>	<b>AGE</b>	<b>P=PAST/ C=CURRENT</b>
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	_____	_____			
Ear aches	_____	_____			
Vision Problems	_____	_____			
Hearing Problems	_____	_____			

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

*Please give details on any “yes” responses:* \_\_\_\_\_

*Is your child currently taking any medications? If “yes”, please list:*

<b>MEDICATION</b>	<b>TAKEN FOR</b>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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: \_\_\_\_\_

***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.***

*(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.

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

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

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

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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?

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***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)
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- 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:**

- |   | <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 follow the 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?**

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

**Who referred you here?**

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

<b>Situation</b>	<b>Year Occurred</b>
<input type="checkbox"/> Parents' divorce	_____
<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 location, house or school	_____
<input type="checkbox"/> Parents hospitalized	_____
<input type="checkbox"/> Parents incarcerated or left 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	_____







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





T A H O E  
**YOUTH & FAMILY**  
 S E R V I C E S  
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:** \_\_\_\_\_