TAHOE YOUTH & FAMILY SERVICES

A SAFETY NET OF SERVICES FOR YOUTH AND FAMILIES

**ADULT**

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.

- 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***

TAHOE YOUTH & FAMILY SERVICES

A SAFETY NET OF SERVICES FOR YOUTH AND FAMILIES

**ADULT**

**CONFIDENTIAL QUESTIONNAIRE**

**Today's Date : _____**

Client # Office Use Only _____

**PLEASE PRINT**

**Client's Legal Name: _____Nickname: _____**

**DOB: _____/____/_____ Age: _____ Sex: ❑ M ❑ F SSN: _____**

**Birthplace: _____Mother's Full Name_____**
**City State**

**Home #: _____ Work #: _____ Cell #: _____**

**May we leave a message: ❑ Y ❑ N Would you like to receive our newsletter by email? ❑ Y ❑ N**
**E-mail Address: _____**

**Current address: _____**
**Street City State Zip**

**Mailing Address: _____**
**Street City State Zip**

**How long have you lived at the above listed residence: _____?**

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

**Present occupation: _____**

**Education: _____Highest degree achieved: _____**

**Emergency contact name: _____**

**Phone: _____ Relationship to client: _____**

**Do you have insurance: ❑ Y ❑ N Please provide primary insured's Social Security #:_____**

**_____ Referred by: _____**

**Name of Insurance Company**

## FAMILY HISTORY

| Please provide information regarding your immediate family, including children.<br><br>If you require additional space, please use the last page. | | | | | |
|---|---|---|---|---|---|
| **First Name** | **Last Name** | **AGE** | **DOB** | **Relationship** | **List any substance abuse or other addictions** |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

| Have you ever been in counseling or therapy or been hospitalized for drug addiction/alcohol/mental health reasons? (Circle one.) Yes No If so, please list below: | | |
|---|---|---|
| **DATE** | **LOCATION** | **LENGTH OF STAY** |
| | | |
| | | |
| | | |
| | | |

# Section 1

**Have you ever experienced any of the following? (Please check all that apply)**

| Now | Past | |
|---|---|---|
| | | **Feelings of sadness or depression** |
| | | **Feelings of hopelessness or guilt** |
| | | **Thoughts of suicide** |
| | | **Lack of caring about anything** |
| | | **Isolation and/or trouble making or keeping friends** |
| | | **Suicide attempt** |
| | | **Losing temper often** |
| | | **Anger, rage or fear towards certain people** |
| | | **Low energy, sleeping more** |
| | | **Withdrawal from family and close friends** |
| | | **Hearing voices when not under the influence of drugs or alcohol** |
| | | **Hallucinations when not under the influence of drugs or alcohol** |
| | | **Head injury (date: ____/____/_____)** |
| | | **Sexual abuse** |
| | | **Physical abuse** |
| | | **Emotional abuse** |
| | | **Witnessed or experienced traumatic event (car crash, earthquake, etc.)** |
| | | **Having access to guns or weapons** |

# Section 2

| Please list all medications you are taking now. If you need more space, please use the bottom of page 10. | |
|---|---|
| **name and dosage of medication** | **health condition requiring this medication** |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

# Section 3

| LEGAL ISSUES | WHEN/WHERE | OUTCOME |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

# Section 4

**Has anyone felt concerned about your drinking or using?** ❑ Yes ❑ No

**Do you feel concerned about your usage or drinking?** ❑ 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 an emergency room/hospital for alcohol/drug related reasons?** ❑ Yes ❑ No

**Has alcohol or drug use caused problems for you at school, at home, in relationships, or at your job?**

**If yes, please explain:** _____

_____

_____

**Have you ever used drugs to numb uncomfortable feelings such as boredom, sadness, anxiety, insomnia (sleeplessness)?** ❑ Yes ❑ No

**Have you ever received outpatient treatment for drug or alcohol use?** ❑ Yes ❑ No

**If yes, when and where? This includes TYFS outpatient, TREC and SAP Program in Juvenile Hall.** _____

_____

**Has any family member received treatment for drug or alcohol use?** ❑ Yes ❑ No

**If yes, when and where?**

_____

**Do you regularly smoke cigarettes?** ❑ Yes ❑ No **How much/how often?** _____ **Age first tried:** _____

**Would you like help to quit?** ❑ Yes ❑ No

**Are you currently pregnant?** ❑ Yes ❑ No

# Section 5

| Substance Use History | | | | | |
|---|---|---|---|---|---|
| **Substance Type** | **How Often** | **How long have you used this substance** | **Age of 1st usage** | **Last usage** | **Route of Administration**<br>-Oral<br>-Smoking<br>-Inhalation<br>-Injection (IV or intramuscular)<br>-None or not applicable<br>-Other |
| **Alcohol** | | | | | |
| **Marijuana** | | | | | |
| **Hallucinogens i.e. (LSD, Mushrooms Etc.)** | | | | | |
| **Cocaine** | | | | | |
| **Crack i.e. Ice** | | | | | |
| **Methamphetamine i.e. (Crank, Speed)** | | | | | |
| **Ecstasy** | | | | | |
| **Pills i.e.Oxycotin,Vicodin,Valium** | | | | | |
| **Inhalants** | | | | | |
| **Heroin, Methadone** | | | | | |
| **Over-the-counter Medication(s)** | | | | | |
| **“Spice”** | | | | | |
| **Other** | | | | | |

# Section 6

**The following questions will allow us to learn more about your current concerns.**

**By giving these questions your full attention, you will help us better assist you.**

1. **Please list some of the problems/issues you are encountering at this time.**

_____

_____

_____

_____

_____

2. **What are some of the current behaviors that concern you the most?**

_____

_____

_____

_____

_____

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

_____

_____

_____

_____

_____

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

_____

_____

_____

5. **Extra Notes Below:**

_____

_____

_____

# Section 7

**Please list three goals you would like to accomplish for yourself/family.**

1. _____

_____

_____

2. _____

_____

_____

3. _____

_____

_____

_____

**Specifically, what do you feel we can do to help you accomplish these goals?**

_____

_____

_____

**Please use the space below for any additional thoughts or concerns you may have OR for any previous questions requiring more space.**

_____

_____

_____

_____

_____

_____

**Client Signature: _____**

**Date: _____**


## 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 50 minutes. Group sessions are 80 minutes in California and 50 minutes in Nevada.

No services will be provided or verification of services 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 (ex. Private Insurance, Medicaid, Medi-Cal)**
Please provide a copy of the health insurance card & the Social Security # of the primary insured.
**Co-Pay Required? Yes ❑ No ❑ Co-Pay Amount: Individual $ _____ Group $ _____**
**Yes ❑ No ❑ Financial Hardship or High Deductible** $75.00 per individual session (Cash or card only)

**Yes ❑ No ❑ CLIENT QUALIFIES FOR ANOTHER TYFS FUNDING SOURCE? (AOD, TRYS, DRYS)**

**Referral Required? Yes ❑ No ❑** **Authorization needed? Yes ❑ No ❑**
**Co-Pay Required? Yes ❑ No ❑**

**Yes ❑ No ❑ CLIENT WISHES TO PAY CASH FOR SERVICES**
$75 fee per individual session; $25 fee per group session.

**Yes ❑ No ❑ Client is requesting a report be sent to the court based on the findings of a Drug & Alcohol Assessment** because of a Nevada DUI offense, the cost is $100 fee per NRS.

**Yes ❑ No ❑ Client is requesting a report be sent to the court based on the findings of a Drug & Alcohol Assessment** fee of $100 (no checks accepted. Cash, CC and debit only). Payment is due in full on first appointment otherwise client cannot be seen. This applies to adult and youth court reports of the finding of an assessment.

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


# NO-SHOW and/or LATE APPOINTMENT CANCELLATION POLICY

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

1. A fee of $50.00 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 will be assessed if I arrive 15 minutes or more after the scheduled appointment. _____ **(Please initial)**
3. The full amount of a counseling session, currently $125.00 (Cash Only), if I do not show for an appointment and have made no contact with the office. _____ **(Please initial)**
4. The full amount of a group session, current $25.00 (Cash Only), if I do not show for group appointment and have name no contact with the office. _____ **(Please initial)**
5. If I miss 2 sessions for unexcused reasons, I will be discharged from services. _____ **(Please initial)**

**If you call over the weekend or after hours, please leave a message at ext. 100**

By signing below, I agree to the above fee determination, policy and stated fees.

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

*TYFS Staff assisting client:* _____

*TYFS Staff: Make a copy of this completed form for the client.*