

STRONGHOLD COUNSELING SERVICES, INC.

625 S. Minnesota Ave Suite 201 • Sioux Falls, South Dakota 57104 • Phone (605) 334-7713

Name _____	Date _____
Address _____	Date of Birth _____ Age _____
City, State _____ Zip _____	Home Phone _____
Employer _____	Social Security # _____
Occupation _____	Business Phone _____
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
Date of Marriage _____	Date of Divorce _____ Date Widowed _____
Number of Children: (circle number) 0 1 2 3 4 5 6 7 8 9 10+ Names and Ages of Children: _____	

Spouse's Name _____	Date of Birth _____	Age _____
Spouse's Employer _____	S.S.# _____	
Telephone _____	Occupation _____	

	PRIMARY INSURANCE CARRIER	SECONDARY INSURANCE CARRIER		
Company Name	_____	_____		
Address	_____	_____		
City, State, Zip	_____	_____		
Phone #	_____	_____		
Insured's	Name	Relation	Name	Relation
	DOB	M F	DOB	M F
	Employer		Employer	
	ID/Group#		ID/Group#	

ASSIGNMENT AND RELEASE: *I hereby agree to pay all co-pays, deductibles, and any amount not covered by my insurance carrier. I understand that all claims are subject to review by my insurance carrier and verification of coverage and benefits made by me or SCS, Inc., are only estimates and SCS, Inc., makes no guarantee of payment by my insurance carrier or health plan. I understand that I am responsible for any amounts not covered by my insurance carrier. I authorize the release of any medical information necessary to process this claim. I authorize payment of benefits to SCS, Inc., unless I have paid my account in full.*

X _____ Date _____
Signature of Client (Parent if Client is Minor)

SCS, Inc., reserves the right to proceed with collections in the event SCS, Inc., is unable to collect payment from me for services rendered within a reasonable period of time.

MEDICARE AUTHORIZATION: *I authorize any holder of medical or other information about me to release to the Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated above or on the HCFA-1500 form, my signature authorizes release of information to the insurer or agency shown.*

X _____ Date _____
Beneficiary Signature

Please complete other side

Number of Siblings: (Circle Number) 0 1 2 3 4 5 6 7 8 9 10+ What is your birth order position? _____

Education (circle highest grade completed) Grade School 1 2 3 4 5 6 7 8 High School 9 10 11 12
 College/Post Grad 13 14 15 16 17 18 19 20+ Highest Degree Earned _____

Spouse's Education (circle highest grade completed) Grade School 1 2 3 4 5 6 7 8 High School 9 10 11 12
 College/Post Grad 13 14 15 16 17 18 19 20+ Highest Degree Earned _____

Number of Siblings: (circle number) 0 1 2 3 4 5 6 7 8 9 10+ What is your spouse's birth order position? _____

Self-Description

Physical Condition	Poor	0	1	2	3	4	5	6	7	8	9	10	Athletic
Intelligence	Stupid	0	1	2	3	4	5	6	7	8	9	10	Bright
Physical Appearance	Ugly	0	1	2	3	4	5	6	7	8	9	10	Attractive
Assertiveness	Shy	0	1	2	3	4	5	6	7	8	9	10	Aggressive
Likeability	Disliked	0	1	2	3	4	5	6	7	8	9	10	Well-liked
Self-confidence	Insecure	0	1	2	3	4	5	6	7	8	9	10	Confident
Coping Style	Anxious	0	1	2	3	4	5	6	7	8	9	10	Relaxed
Personal Worth	Bad	0	1	2	3	4	5	6	7	8	9	10	Good

List some particularly positive things about yourself (assets, talents, etc.) _____

List some particularly negative things about yourself (faults, deficiencies, etc.) _____

Referred by _____

Previous Counseling with _____

Church Membership _____

Briefly state why you are here _____

Medical Information

Physician _____ Medical Problems _____

Address _____ Medication _____

Phone _____

Any pertinent medical information _____

Person to contact in case of emergency

Name _____ Relationship _____

Address _____ Phone _____