Welcome to the Stronghold Counseling Services, Inc.

4300 S. Louise Ave., Suite 201, Sioux Falls, SD 57106
www.strongholdcounseling.com
PHONE 605-334-7713; FAX 605-334-5348

Stronghold was created in 1993 to offer Hope... the hope of real healing for those hurting in a broken world. Healing never takes place alone. Many times, it is the result of deliberate, intentional, caring service from committed professionals with years of experience... professional counselors who have already helped hundreds in similar situations. This hope is the foundation of the Stronghold experience.

HOPE WITHOUT HYPE

Healing is never easy. There is no quick fix. It is often painful. It does not happen overnight. But real, life-changing healing can and does happen regardless of what often may seem like a mountain of overwhelming circumstances. True, we don't know what you're going through. But at Stronghold, you'll never have to face it alone.

GUIDANCE WITHOUT JUDGMENT

Stronghold was founded on a philosophy of non-judgmental counseling. Before healing can happen, open communication must take place in a safe environment free of judgment. Stronghold provides a "judgment-free" zone where individuals and families can honestly open-up, often for the first time without any fear of repercussions.

Here at Stronghold, we promise:

1) To actively listen with compassion and understanding. We will be respectful and provide caring support in a friendly, comfortable, and welcoming setting.

2) To work hard to earn your trust every day in helping find answers to the problems causing distress.

3) To provide the highest level of quality, non-judgmental counseling based on years of experience in dealing with others who have had similar problems.

4) To provide a refuge based on the Christ-like principle giving Grace to those who are hurting. We eagerly welcome all people regardless of culture or creed.

If you are new to the mental health clinic or have not been seen in over one year:

- Please complete the full intake packet.
- Give the packet, your ID card, your insurance card and the date of birth of the insurance policy's main subscriber to the front desk staff.

Hope without Hype, Guidance without Judgement

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Adult Information *(fill out if you are the client)*

Date:_____

Client Name: _____ Gender: ☐ Male ☐ Female ☐ Other

Address: _____ Date of Birth: ___/___/_____ Age: _____

City, State: _____ Zip: _____ Cell Phone: _____

Email Address: _____ **Appointment Reminders** Phone or Email (Please circle one)

Employment Status: ☐ Student ☐ Employed ☐ Unemployed ☐ Homemaker ☐ Retired ☐ Other: _____

Employer: _____ SSN: _____

Occupation: _____ Business Phone: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Date of Marriage: _____ Date of Divorce: _____ Date Widowed: _____

Number of children: _____ Names and Ages: _____

Spouse's Name: _____ Date of Birth: _____ Age: _____

Spouse's Employer: _____ SSN: _____

Occupation: _____ Business Phone: _____

Adolescent Information *(fill out if your child is the client)*

Date:_____

Client Name: _____ Gender: ☐ Male ☐ Female ☐ Other

Address: _____ Date of Birth: _____ Age:_____

City, State: _____ Zip: _____ Contract Number: _____

Email Address: _____ **Appointment Reminders** Phone or Email (Please circle one)

Father's Name: _____ Date of Birth: _____ Age: _____

Employment Status: ☐ Student ☐ Employed ☐ Unemployed ☐ Homemaker ☐ Retired ☐ Other: _____

Employer: _____ SSN: _____

Occupation: _____ Business Phone: _____

Mother's Name: _____ Date of Birth: _____ Age: _____

Employment Status: ☐ Student ☐ Employed ☐ Unemployed ☐ Homemaker ☐ Retired ☐ Other: _____

Employer: _____ SSN: _____

Occupation: _____ Business Phone: _____

Stepparent's Name: _____ Date of Birth: _____ Age: _____

Employment Status: ☐ Student ☐ Employed ☐ Unemployed ☐ Homemaker ☐ Retired ☐ Other: _____

Employer: _____ SSN: _____

Occupation: _____ Business Phone: _____

Insurance Information *(Please fill out)*

Employee Assistant Program (EAP) ☐ Yes ☐ No If yes please list EAP name _____

Authorization Number _____ Number of Sessions _____

Primary Insurance _____ Member ID _____ Group Number _____

Insured's Name _____ Date of Birth _____ Gender: ☐ Male ☐ Female

Secondary Insurance _____ Member ID _____ Group Number _____

Insured's Name _____ Date of Birth _____ Gender: ☐ Male ☐ Female

Number of Siblings: _____ What is your birth order position? _____ Highest Education Completed: _____

Emergency Contact

Name _____ Relationship _____

Address _____ Phone Number _____

What is your primary reason for seeking help?

Are you currently experiencing a crisis?

☐ Yes

Explain: _____

☐ No

What convinced you to get help now?

What kind of help are you seeking? Select all that apply:

☐ Individual therapy /counseling	☐ Medication management (BHS)	☐ Group counseling
☐ Couples counseling (BHS)	☐ Substance use counseling (BHS)	☐ Academic Counseling (SCS)
☐ Career counseling (SCS)	☐ Medical social work/Case management	

Other:

How did you happen to come to Stronghold Counseling Services, Inc. (check all that apply):

☐	School: _____	☐	EAP	☐	Internet
☐	Avera Doctor: _____	☐	BNI	☐	Local Best
☐	Sanford Doctor: _____	☐	Call to Freedom	☐	Phone Book
☐	Clergy/Pastoral: _____	☐	Family	☐	Parenting Class
☐	Department of Social Services	☐	Friend	☐	Other: _____

Previous Treatments: (check all that apply)

Psychiatric: ☐ None ☐ Outpatient ☐ Inpatient -- ☐ within last 12 months ☐ One prior admission ☐ 2 or more admissions

Substance Abuse: ☐ None ☐ Outpatient ☐ Inpatient -- ☐ within last 12 months ☐ One prior admission ☐ 2 or more admissions

Current Symptoms Checklist: (check once for any symptoms present)

☐ Depressed mood	☐ Elevated Mood	☐ Dissociative States
☐ Decreased Energy	☐ Irritable	☐ Oppositional
☐ Grief	☐ Impulsive	☐ Somatic Complaints
☐ Hopelessness	☐ Hyperactivity	☐ Emotional Trauma
☐ Worthlessness	☐ Disruption of Thought	☐ Physical Trauma
☐ Guilt	☐ Process/Content	☐ Sexual Trauma
☐ Anxious	☐ Delusions	☐ Active Substance Abuse
☐ Panic Attacks	☐ Hallucinations	☐ _____
☐ Obsessive/Compulsions	☐ Paranoia	☐ _____

Please assess the level of impairment your current symptoms are causing in the following categories. Check the number that best applies.

	1= none	2= mild	3= moderate	4= significant	5= extreme
Marriage/Relationship/Family	☐	☐	☐	☐	☐
Job/School Performance	☐	☐	☐	☐	☐
Friendships/Peer Relationships	☐	☐	☐	☐	☐
Financial Situation	☐	☐	☐	☐	☐
Hobbies/Interests	☐	☐	☐	☐	☐
Physical Health	☐	☐	☐	☐	☐
Personal Hygiene	☐	☐	☐	☐	☐
Eating habits Recent Weight loss?: ___ lbs. Recent Weight gain?: ___ lbs. Current weight: ____ lbs. Height ___ft. ___in.	☐	☐	☐	☐	☐
Sleeping Habits Check all that apply: ☐: Difficulty Falling Asleep ☐ : Difficulty Staying Asleep ☐: Early Awakening	☐	☐	☐	☐	☐
Sexual Functioning	☐	☐	☐	☐	☐
Ability to Concentrate	☐	☐	☐	☐	☐
Ability to Control Temper	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐

Risk Assessment (Check all that apply)

Suicidal: ☐ Not Present ☐ Ideation ☐ Plan ☐ Means ☐ Prior Attempt Date: _____

Homicidal: ☐ Not Present ☐ Ideation ☐ Plan ☐ Means ☐ Prior Attempt Date: _____

Current Psychiatric Medications: Current medications, please indicate the dates, dosage, and how helpful they were (if you can't remember all the details, just write in what you do remember).

Antidepressants	Dates	Dosage	Side effects/Response
☐ Prozac (fluoxetine)			
☐ Zoloft (sertraline)			
☐ Luvox (fluvoxamine)			
☐ Paxil (paroxetine)			
☐ Celexa (citalopram)			
☐ Lexapro (escitalopram)			
☐ Effexor (venlafaxine)			

☐ Wellbutrin (bupropion)			
☐ Remeron (mirtazapine)			
Antidepressants	**Dates**	**Dosage**	**Side effects/Response**
☐ Anafranil (clomipramine)			
☐ Pamelor (nortrptyline)			
☐ Elavil (amitriptyline)			
☐ Other:			

Mood Stablizers	**Dates**	**Dosage**	**Side effects/Response**
☐ Tegretol			
☐ Serzone			
☐ Lithium			
☐ Depakote			
☐ Lamictal			
☐ Topamax			
☐ Other:			

Antipsychotics/Mood	**Dates**	**Dosage**	**Side effects/Response**
☐ Seroquel			
☐ Zyprexa			
☐ Geodon			
☐ Abilify			
☐ Clozaril			
☐ Haldol			
☐ Prolixin			
☐ Risperadal			
☐ Other:			

Sedative/Hypnotics	**Dates**	**Dosage**	**Side effects/Response**
☐ Ambien			
☐ Sonata			
☐ Restoril			
☐ Desyrel			
☐ Other:			

ADHD medications	**Dates**	**Dosage**	**Side effects/Response**
☐ Adderall			
☐ Concerta			
☐ Ritialin			
☐ Strattera			
☐ Dexedrine			
☐ Vyvance			
☐ Focalin			
☐ Intuniv			
☐ Clonidine			
☐ Other:			

Antianxiety medications	**Dates**	**Dosage**	**Side effects/Response**
☐ Xanax			
☐ Ativan			

☐ Clonopin			
☐ Valium			
Antianxiety medications	**Dates**	**Dosage**	**Side effects/Response**
☐ Tranxene			
☐ buspar			
☐ Cymbalta			
☐ Luvox			
☐ Effexor XR			
☐ Anafrani			
☐ Norpramin			
☐ Sinequan			
☐ Neurontin			
☐ Lyrica			
☐ Tenormin			
☐ Corgard			
☐ Inderal			
☐ Betachron E-R			
☐ InnoPran XL			
☐ Other:			

Prescribing Physician/Psychiatrist: _____

Medication Allergies

Family Mental Health History

	Mother	Father	Sibling	Other (List)	What treatment?
Anxiety	☐	☐	☐		
Depression	☐	☐	☐		
Bipolar Disorder	☐	☐	☐		
Substance Abuse	☐	☐	☐		
Other	☐	☐	☐		

Family Medical Health History

	Mother	Father	Sibling	Other (List)
Diabetes	☐	☐	☐	
Heart Problems	☐	☐	☐	
High Blood Pressure	☐	☐	☐	
High Cholesterol	☐	☐	☐	
Thyroid	☐	☐	☐	

Are you concerned about past or present alcohol or drug use?	☐	Yes	☐	No

If yes, please describe
