Welcome to Stronghold Counseling Services, Inc.

4300 S. Louise Ave., Suite 201, Sioux Falls, SD 57106

610 West 23rd Street #8, Yankton, SD 57078

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PHONE: 605-334-7713 **FAX:** 605-334-5348

Hope without Hype, Guidance without Judgment

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.

Stronghold Counseling Services

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

Date: ____________________

Client Name (adult): ______________________________ 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: ______________________

Date: ____________________ **Minor Client Information** *(fill out if your child is the client)*

Client Name (minor): ______________________________ Gender: ☐ Male ☐ Female ☐ Other

Address: ______________________________ Date of Birth: ______________ Age: _____

City, State: ______________________ Zip: _______ Responsible Party Phone 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: ______________________________ Contact Phone: ______________________

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

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

Employer: ______________________________ SSN: ______________________

Occupation: ______________________________ Contact Phone: ______________________

Stepparent(s) Name(s): ______________________________ Date(s) of Birth: ______________ Age(s): _____

Stepparent(s) Name(s): ______________________________ Date(s) of Birth: ______________ Age(s): _____

Employer(s): ________________ SSN: ______________________ Contact Phone(s): ______________

Emergency Contact

Name: ______________________________ Relationship: ______________________

Address: ______________________________ Phone Number: ______________________

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: ___________

Primary Physician

Name: ______________________________ Phone Number: ___________________________

What is your primary reason for seeking help? ____

Are you currently experiencing a crisis? Explain: ______________________________________

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

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

If yes, please describe: ____

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	☐	☐	☐	