Stronghold Counseling Services

Date:_______________________

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

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

City, State: ____________________________ Zip: _________ Contact 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: ______________________________

(fill out if client is a minor)

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

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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 is your current mental health diagnosis? ____

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).

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	☐	☐	☐	