Conscious Living Counseling & Education Center

3239 Oak Ridge Loop East, West Fargo ND 58078 (701) 478-7199

INTAKE FORM

BIRTH DATE:	___ ___ / ___ ___ / ___ ___	Age: _____	Email: _____

YOUR NAME		
FIRST:	MIDDLE INITIAL:	LAST:

YOUR ADDRESS			
COMPLETE ADDRESS:	CITY:	STATE:	ZIP:

CONTACT NUMBERS		May we contact you at this number?	May we leave a message at this number?
CELL OR OTHER			

EMERGENCY CONTACT INFORMATION	
NAME & RELATIONSHIP:	Number:

YOUR INSURANCE INFORMATION	
PROVIDER/COMPANY NAME:	POLICY ID:

If you are not the primary policy holder, please complete the next box. ☐ I am the primary policy holder

PRIMARY INSURANCE HOLDER (Example: If your insurance is under your mother's name, her information should go in this box.) If you have your own policy, do not complete this box.			
PRIMARY INSURANCE FIRST NAME:	MIDDLE INITIAL:	LAST NAME:	
STREET ADDRESS:	CITY:	STATE:	ZIP:
PRIMARY INSURED DATE OF BIRTH: ____ ____ / ____ ____ / 19 ____ ____	TELEPHONE:	RELATIONSHIP: ☐ Parent ☐ Other ☐ Spouse	

PLEASE NOTIFY US IF: ☐ You have a secondary insurance policy ☐ Bill should be sent to guardian/parent

(Because we want to talk with you, not spend the hour collecting basic data, please complete form. Thank you!)

CURRENT CONCERN (please circle all that apply)		
• ADHD • Anger • Anxiety • Body image • Chronic pain • Depression	• Employment problems • Frequent conflict with others • Grief or loss • Major changes • Legal problems • Panic	• Parenting Concerns • Relationship concerns • Sexual concerns • Trauma • Other:
Have you see a counselor before? **If so when?**		

IMMEDIATE FAMILY			
Name	Relationship	Age	Living with you?

RELATIONSHIP & PARTNER HISTORY	
Are you currently in a relationship?	
Length of time in relationship?	
How many significant relationships/partners have you had before this partner?	
How do your relationships typically end?	
How many times have you been married?	
Are your parents still together? If no, how old were you when they divorced?	

PERSONAL HISTORY
Are there any special circumstances that have impacted your upbringing or development? If Yes, please describe:
Have there been any traumatic experiences that have impacted your life? If Yes, please describe:
Has there been a *history or current* concern about physical or sexual abuse in your family or life?

EDUCATION & LEARNING	
Highest level of education completed?	
Where? When did you / will you graduate?	
Have you ever been diagnosed with a learning disability?	☐ NO ☐ YES : ADHD / Dyscalculia / Dysgraphia / Dyspraxia / Dyslexia
DO you know your learning style? (Circle all that apply)	☐ I prefer written materials ☐ I prefer a demonstration before doing ☐ I prefer verbal instructions ☐ I need context to understand new info

EMPLOYMENT	
Where you are currently employed?	
When did you start the position?	

SOCIAL RELATIONSHIPS	
Do you have friends and family to support you?	
Do you identify with any cultural/ethnicity and/or religion?	
Are you currently having any criminal or legal problems?	

DEPRESSION ASSESSMENT

Over the last 2 weeks, how often have you been bothered by any of the following problems?	**No, not at all**	**Yes, but only mildly**	**Yes, but I can stand it**	**I can barely stand it**
a. Little interest or pleasure in doing things				
b. Feeling down, depressed, or hopeless				
c. Trouble falling or staying asleep, or sleeping too much				
d. Feeling tired or having little energy				
e. Poor appetite or overeating				
f. Feeling bad about yourself - or that you are a failure or have let yourself or your family down				
g. Trouble concentrating on things, such as reading the newspaper or watching television				
h. Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual				
i. Thoughts that you would be better off dead or of hurting yourself in some way				

ANXIETY ASSESSMENT

Have you been bothered by any of the following problems?	No	Yes
a. In the last six months have you found it difficult to control worry or anxiety?		
b. Does feeling anxious ever impact your relationships or job performance?		

c. Does anxiety causes physical symptoms such as restlessness, fatigue, difficulty concentrating, irritability, muscle tension or difficulty sleeping?		
d. In the last 4 weeks, have you had a *panic attack* – suddenly feeling fear or panic?		
e. Do these attacks bother you a lot or are you worried about having another attack?		
f. Do you ever avoid social settings or public places because these settings increase anxiety?		

MENTAL HEALTH & MEDICAL HISTORY – Please Complete

Have you ever been diagnosed with a mental health condition?	Year Diagnosed
Condition:	
Condition:	
Condition:	
Condition:	
Are you currently managing a medical condition?	
Condition:	
Condition:	
Condition:	
Condition:	
Hormone/Reproductive (Women Only Section)	
Are you taking birth control? Type? Did problem worsen of improve after starting?	
Are you still menstrating? Date of last period?	
Are you experiencing any reproductive concerns?	

SELF-CARE

1. Eating habits? (Circle)	Poor (diet high in processed food, very few or no fruits and veggies)	Fair (few serving of fruits veggies a day)	Good (Diet rich in fruits and veggies, quality protein, and avoid processed food)
2. Average glasses of water per day? (Circle)	0 - 1	3 - 4	5 - 8
3. Rate your stress level: (Circle)	0 no stress- - - -3 mild- - - -5 moderate- - - -8 overwhelmed- - - -10 Not coping (lowest) (highest)		
4. Number of days you exercise per week?	Number:	Type of physical activity:	
5. Please describe your use of recreational drugs and alcohol:			

SLEEP

Average time you crawl into bed?	

Average time it take you to fall asleep?	Under 15.min	Over 15 min.	Over 30 min
How many times do you wake during the night?	Under 5x	Over 5x	Between 5-10x
Total sum awake time during the night	Under 15.min	Over 15 min.	Over 30 min
Time you get out of bed?			
Do you snore or wake gasping for air:	Yes	No.	Maybe
Do you wake feeling well rested?			

MEDICATIONS

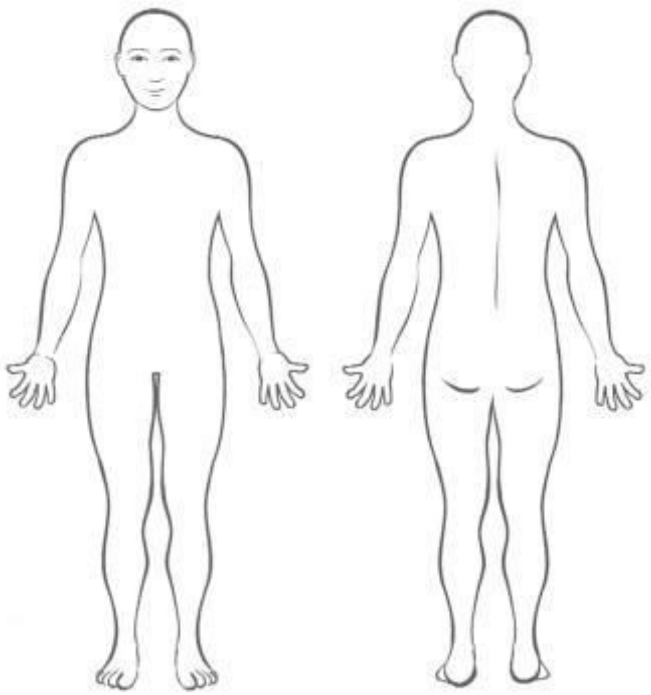
NAME:	Dosage?	How long?

PRIMARY MEDICAL PROVIDER

PROVIDER'S NAME:	NETWORK:	DATE OF LAST CHECK-UP?

Circle any area of the body that you experience pain, inflammation, discomfort and/or medical problems on a regular basis:

Check if you have problems with ☐ Blood Pressure ☐ Blood Sugar ☐ Hormones ☐ Autoimmune/Illness



Please bring your insurance cards to your first appointment.

Payment

If your coverage requires a co-payment please bring a means of payment (cash, check, or credit card) to your appointment. Co-insurance or deductible amounts are due after your insurance processes and you receive the explanation of benefits from your insurance carrier. You will receive a bill from Conscious Living Counseling stating the amount due and due date.

All self-pay are due at the time of service. We can provide you with an itemized receipt for submission to a health savings account, by request.

Claims filing

Our staff will file a claim with your insurance carrier. We will work with you to obtain the benefits you deserve; but, remember, you are accountable for the "patient responsibility" portion of our charges.

Questions

Call the office between 9:00 am and 5:00 pm Monday through Friday. Thank you!

Parking

Pleased arrive at the time of your appointment. Parking is limited to patients being seen. If there are no spots, please wait until a spot opens or use off-street parking.

Directions

We are located at 3239 Oak Ridge Loop East, West Fargo. We are located in the business park directly behind Maximum Performance Gym and Faith Hands Daycare on 32nd avenue. (1) **Turn left** on **6th Street East** (at the Oak Ridge sign) and (2) take the **first right** on Oak Ridge Way (ignore any construction signs), which will bring you to the business loop. (3)Take the **second left** turn on Oak Ridge Loop. Oak Ridge Loop road is a loop and has two entry points. See map.

Google Map: 3239 Oak Ridge Loop East, West Fargo, 58078
or "*Oak Ridge Office Park*"

NOTES: