

NEW PATIENT INTAKE FORM  
Melissa Sophia Joy, ND  
Naturopathic Doctor, Founder of Somatic Awakening®,  
Medical Intuitive and Spiritual Teacher

Specializing in Mind-Body-Spirit Counseling with a focus on Chronic Illness,  
Women's Health and Hormonal/Emotional Balance

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[www.somatic-awakening.com](http://www.somatic-awakening.com)

O: 707-859-7977 F: 707-921-7942 C: 707-332-4172 (For Urgent Concerns Only)

Patient Information (Please print and complete in full)

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Full Address: \_\_\_\_\_

Email: \_\_\_\_\_

Home and/or Mobile Telephone #: \_\_\_\_\_ Work Telephone #: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex \_\_\_\_\_ Social Security # \_\_\_\_\_

Referred By/How did you hear about us: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency Contact Phone #1: \_\_\_\_\_ Emergency Phone #2: \_\_\_\_\_

Employment Status:

Full Time  Part Time  Retired  Unemployed  Student  Home Engineer  Disabled

Occupation: \_\_\_\_\_

Employer's Name: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Partner's Name if applicable: \_\_\_\_\_

Partner's Employer: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Partner's Employer's Address: \_\_\_\_\_

Primary Health Care Source (HMO, Community Clinic, Emergency Room, Alternative Medicine, etc.):

Physician's Name: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

Date of last Physician Visit: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Are you presently being treated for a medical condition? If yes, please describe?

\_\_\_\_\_

Have you ever seen a naturopathic doctor before? If yes, when and for what reason? \_\_\_\_\_

\_\_\_\_\_

What issue(s) do you want treated? Please describe as fully as possible: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

When did this/these issue(s) or illness(es) begin? \_\_\_\_\_

\_\_\_\_\_

What types of treatment have you tried for relief of this issue? \_\_\_\_\_

\_\_\_\_\_

Do you have other health or emotional, energetic, life concerns that you want addressed or feel that may be related to what's happening with you? If so, please describe.

\_\_\_\_\_

\_\_\_\_\_

Please describe any trauma history that you feel may be connected to what's happening with you.

\_\_\_\_\_

\_\_\_\_\_

Do you experience psychological/emotional issues, such as overwhelm/high anxiety, trauma flashbacks, etc.? If yes, please describe. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Have you received a diagnoses for the physical or psychological issues you want treated? If yes, what have you been diagnosed with? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If you would like to include a focus on your physical health and Naturopathic Medicine in your sessions, please fill out the remaining intake form. If you solely desire to address a non-health related issue, but one that is solely spiritual, emotional, or focus on life direction then you do not need to fill out the remaining form.

Please describe the foods you eat regularly:

Breakfast: \_\_\_\_\_  
Morning Snack: \_\_\_\_\_  
Lunch: \_\_\_\_\_  
Afternoon Snack: \_\_\_\_\_  
Dinner: \_\_\_\_\_  
Evening Snack: \_\_\_\_\_

Do you exercise regularly?  Yes  No

What type of exercise do you do? \_\_\_\_\_

Family History: Complete for each family member, placing an X in the appropriate box:

	Self	Mother	Father	Sister	Brother	Spouse	Child
Allergies							
Blood Disorder/Anemia							
Diabetes							
Cancer or Tumors							
Seizures							
High Blood Pressure							
Kidney or Bladder Disorder							
Stomach or Intestinal Disorder							
Drug Abuse							

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Tuberculosis							
Heart Disease							
Stroke							
Depression/Mental Illness							
Other							
Age at Death							

Major Hospitalizations: If you have ever been hospitalized for any serious medical illness or operation, write in your most recent hospitalizations below.

Year	Operation or Illness	Name of Hospital	City and State

Have you had any serious medical issues and/or diagnosis in the past? If so, what were they and what were you diagnosed with then? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Pregnancy History:

Year	Length of pregnancy	Length of Labor	Type of Delivery	Sex	Weight	Name	Notes

Total Pregnancies \_\_\_\_ Living \_\_\_\_ Ectopic \_\_\_\_ Miscarriages \_\_\_\_ Induced Abortions \_\_\_\_

Medicines: Mark an X in the box next to any of the following that you are now taking:

<input type="checkbox"/> aspirin	<input type="checkbox"/> ibuprofen	<input type="checkbox"/> acetaminophen (Tylenol)	<input type="checkbox"/> Other:
<input type="checkbox"/> antacids	<input type="checkbox"/> laxatives	<input type="checkbox"/> cold tablets	

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

<input type="checkbox"/> oral contraceptives	<input type="checkbox"/> diet pills	<input type="checkbox"/> tranquilizers	
<input type="checkbox"/> fiber supplements	<input type="checkbox"/> sleeping pills	<input type="checkbox"/> hay fever tablets	
<input type="checkbox"/> blood pressure pills	<input type="checkbox"/> blood thinning pills	<input type="checkbox"/> insulin, diabetic medicines	

What Vitamins do you currently take (please list):

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What Herbs do you currently take (please list):

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DRUG ALLERGIES: \_\_\_\_\_

Please check all that apply:

GENERAL	CARDIOVASCULAR	FEMALE
<p>past current</p> <input type="checkbox"/> <input type="checkbox"/> Poor appetite <input type="checkbox"/> <input type="checkbox"/> Excessive appetite <input type="checkbox"/> <input type="checkbox"/> Insomnia <input type="checkbox"/> <input type="checkbox"/> Fatigue <input type="checkbox"/> <input type="checkbox"/> Fevers <input type="checkbox"/> <input type="checkbox"/> Night sweats <input type="checkbox"/> <input type="checkbox"/> Sweat easily <input type="checkbox"/> <input type="checkbox"/> Chills <input type="checkbox"/> <input type="checkbox"/> Localized weakness <input type="checkbox"/> <input type="checkbox"/> Poor coordination <input type="checkbox"/> <input type="checkbox"/> Change in appetite <input type="checkbox"/> <input type="checkbox"/> Strong thirst <input type="checkbox"/> <input type="checkbox"/> Other	<p>past current</p> <input type="checkbox"/> <input type="checkbox"/> High blood pressure <input type="checkbox"/> <input type="checkbox"/> Low blood pressure <input type="checkbox"/> <input type="checkbox"/> Blood clots <input type="checkbox"/> <input type="checkbox"/> Palpitations <input type="checkbox"/> <input type="checkbox"/> Fainting <input type="checkbox"/> <input type="checkbox"/> Phlebitis <input type="checkbox"/> <input type="checkbox"/> Chest pain <input type="checkbox"/> <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> <input type="checkbox"/> Cold hands/feet <input type="checkbox"/> <input type="checkbox"/> Swelling of hands/feet <input type="checkbox"/> <input type="checkbox"/> Other	<p>past current</p> <input type="checkbox"/> <input type="checkbox"/> Freq. urinary tract infections <input type="checkbox"/> <input type="checkbox"/> Freq. vaginal infections <input type="checkbox"/> <input type="checkbox"/> Pain/itching of genitalia <input type="checkbox"/> <input type="checkbox"/> Genital lesions/discharge <input type="checkbox"/> <input type="checkbox"/> Pelvic Inflammatory Disease <input type="checkbox"/> <input type="checkbox"/> Abnormal pap smear <input type="checkbox"/> <input type="checkbox"/> Irregular periods <input type="checkbox"/> <input type="checkbox"/> Painful menstrual periods <input type="checkbox"/> <input type="checkbox"/> Premenstrual syndrome <input type="checkbox"/> <input type="checkbox"/> Abnormal bleeding <input type="checkbox"/> <input type="checkbox"/> Menopausal syndrome <input type="checkbox"/> <input type="checkbox"/> Breast lumps <input type="checkbox"/> <input type="checkbox"/> Other

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

SKIN	RESPIRATORY	MALE
<p>past current</p> <input type="checkbox"/> <input type="checkbox"/> Rashes <input type="checkbox"/> <input type="checkbox"/> Hives <input type="checkbox"/> <input type="checkbox"/> Itching <input type="checkbox"/> <input type="checkbox"/> Eczema <input type="checkbox"/> <input type="checkbox"/> Pimples <input type="checkbox"/> <input type="checkbox"/> Dryness <input type="checkbox"/> <input type="checkbox"/> Tumors, lumps <input type="checkbox"/> <input type="checkbox"/> Changes in moles or lumps <input type="checkbox"/> <input type="checkbox"/> Bruise easily	<p>past current</p> <input type="checkbox"/> <input type="checkbox"/> Asthma or Wheezing <input type="checkbox"/> <input type="checkbox"/> Bronchitis <input type="checkbox"/> <input type="checkbox"/> Frequent colds <input type="checkbox"/> <input type="checkbox"/> Chronic Pulmonary Disease <input type="checkbox"/> <input type="checkbox"/> Pneumonia <input type="checkbox"/> <input type="checkbox"/> Cough <input type="checkbox"/> <input type="checkbox"/> Coughing blood <input type="checkbox"/> <input type="checkbox"/> Production of phlegm <input type="checkbox"/> <input type="checkbox"/> Other	<p>past current</p> <input type="checkbox"/> <input type="checkbox"/> Pain/itching of genitalia <input type="checkbox"/> <input type="checkbox"/> Genital lesions/discharge <input type="checkbox"/> <input type="checkbox"/> Impotence <input type="checkbox"/> <input type="checkbox"/> Weak urinary stream <input type="checkbox"/> <input type="checkbox"/> Lumps in testicles <input type="checkbox"/> <input type="checkbox"/> Other
HEAD AND NECK	EARS	NEUROLOGICAL
<p>past current</p> <input type="checkbox"/> <input type="checkbox"/> Dizziness <input type="checkbox"/> <input type="checkbox"/> Fainting <input type="checkbox"/> <input type="checkbox"/> Neck stiffness <input type="checkbox"/> <input type="checkbox"/> Enlarged lymph glands <input type="checkbox"/> <input type="checkbox"/> Headaches <input type="checkbox"/> <input type="checkbox"/> Concussions <input type="checkbox"/> <input type="checkbox"/> Other	<p>past current</p> <input type="checkbox"/> <input type="checkbox"/> Infection <input type="checkbox"/> <input type="checkbox"/> Ringing <input type="checkbox"/> <input type="checkbox"/> Decreased hearing <input type="checkbox"/> <input type="checkbox"/> Other	<p>past current</p> <input type="checkbox"/> <input type="checkbox"/> Seizures <input type="checkbox"/> <input type="checkbox"/> Tremors <input type="checkbox"/> <input type="checkbox"/> Numbness or tingling of limbs <input type="checkbox"/> <input type="checkbox"/> Concussion <input type="checkbox"/> <input type="checkbox"/> Pain <input type="checkbox"/> <input type="checkbox"/> Paralysis <input type="checkbox"/> <input type="checkbox"/> Other
EYES	GENITO-URINARY	NOSE, THROAT AND MOUTH
<p>past current</p> <input type="checkbox"/> <input type="checkbox"/> Blurred vision <input type="checkbox"/> <input type="checkbox"/> Visual changes <input type="checkbox"/> <input type="checkbox"/> Poor night vision <input type="checkbox"/> <input type="checkbox"/> Spots <input type="checkbox"/> <input type="checkbox"/> Glasses/Contacts <input type="checkbox"/> <input type="checkbox"/> Eye inflammation <input type="checkbox"/> <input type="checkbox"/> Other	<p>past current</p> <input type="checkbox"/> <input type="checkbox"/> Kidney stones <input type="checkbox"/> <input type="checkbox"/> Pain on urination <input type="checkbox"/> <input type="checkbox"/> Frequent urination <input type="checkbox"/> <input type="checkbox"/> Blood in urine <input type="checkbox"/> <input type="checkbox"/> Urgency to urinate <input type="checkbox"/> <input type="checkbox"/> Unable to hold urine <input type="checkbox"/> <input type="checkbox"/> Other	<p>past current</p> <input type="checkbox"/> <input type="checkbox"/> Nose bleeds <input type="checkbox"/> <input type="checkbox"/> Sinus infection <input type="checkbox"/> <input type="checkbox"/> Hay fever or allergies <input type="checkbox"/> <input type="checkbox"/> Grinding teeth <input type="checkbox"/> <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> <input type="checkbox"/> Sore throat or hoarseness <input type="checkbox"/> <input type="checkbox"/> Changes in taste or smell <input type="checkbox"/> <input type="checkbox"/> Mouth sores

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

GASTRO-INTESTINAL	PSYCHOLOGICAL	MUSCLE AND JOINT
<p>past current</p> <input type="checkbox"/> <input type="checkbox"/> Nausea <input type="checkbox"/> <input type="checkbox"/> Vomiting <input type="checkbox"/> <input type="checkbox"/> Diarrhea <input type="checkbox"/> <input type="checkbox"/> Belching <input type="checkbox"/> <input type="checkbox"/> Blood in stools/black stools <input type="checkbox"/> <input type="checkbox"/> Bad Breath <input type="checkbox"/> <input type="checkbox"/> Rectal pain <input type="checkbox"/> <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> <input type="checkbox"/> Constipation <input type="checkbox"/> <input type="checkbox"/> Pain or cramps <input type="checkbox"/> <input type="checkbox"/> Gas or Indigestion <input type="checkbox"/> <input type="checkbox"/> Recent change in weight <input type="checkbox"/> <input type="checkbox"/> Other	<p>past current</p> <input type="checkbox"/> <input type="checkbox"/> Depression <input type="checkbox"/> <input type="checkbox"/> Anxiety/Stress <input type="checkbox"/> <input type="checkbox"/> Irritability <input type="checkbox"/> <input type="checkbox"/> Treated for emotional/psychological problem <input type="checkbox"/> <input type="checkbox"/> Frequent nightmares <input type="checkbox"/> <input type="checkbox"/> Other	<p>past current</p> <input type="checkbox"/> <input type="checkbox"/> Joint disorder <input type="checkbox"/> <input type="checkbox"/> Sore/Weak muscles <input type="checkbox"/> <input type="checkbox"/> Difficulty walking <input type="checkbox"/> <input type="checkbox"/> Spinal curvature <input type="checkbox"/> <input type="checkbox"/> Backache <input type="checkbox"/> <input type="checkbox"/> Back pain <input type="checkbox"/> <input type="checkbox"/> Other