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

drmelissasophiajoy@gmail.com

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:_______________

City:_______________ State:________ Zip:_______________

Email:_______________

Home and/or Mobile Telephone #:_______________ Work Telephone #:_______________

Birth Date:_______________ Age:_______________ Gender_______________ Preferred Pronouns_______________

Social Security #_______________ (Requested by Labs)

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 #: _______________

Patient Name: ____Date:____________________________

Physician's Address:____

Date of last Physician Visit:___________________

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							

Patient Name: ____Date:____________________________

Drug Abuse							
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:

☐ aspirin	☐ ibuprofen	☐ acetaminophen (Tylenol)	☐ Other:

Patient Name: ____Date:__________________________

☐ antacids	☐ laxatives	☐ cold tablets	
☐ oral contraceptives	☐ diet pills	☐ tranquilizers	
☐ fiber supplements	☐ sleeping pills	☐ hay fever tablets	
☐ blood pressure pills	☐ blood thinning pills	☐ insulin, diabetic medicines	

What supplements/vitamins/herbs do you currently take (please list):

____

____

____

____

____

____

____

____

DRUG ALLERGIES: ____

Please check all that apply:

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

Patient Name: ____Date:____________________________

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

Patient Name: ____Date:________________________

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