NEW PATIENT INTAKE FORM

Melissa Sophia Joy, ND

Naturopathic Doctor, Founder of Somatic Awakening®, Medical Intuitive and Spiritual Teacher

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

drmelissasophiajoy@gmail.com
www.somatic-awakening.com
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: _____ What Pronoun Preferred: _____

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.

_____

_____

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 spiritual, emotional, energetic, 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							

Patient Name: _____ Date: _____

Seizures							
High Blood Pressure							
Kidney or Bladder Disorder							
Stomach or Intestinal Disorder							
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 Medications:
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:

Patient Name: _____ Date: _____

GENERAL	CARDIOVASCULAR	FEMALE
past current Poor appetite Excessive appetite Insomnia Fatigue Fevers Night sweats Sweat easily Chills Localized weakness Poor coordination Change in appetite Strong thirst Other	past current High blood pressure Low blood pressure Blood clots Palpitations Fainting Phlebitis Chest pain Irregular heart beat Cold hands/feet Swelling of hands/feet Other	past current Freq. urinary tract infections Freq. vaginal infections Pain/itching of genitalia Genital lesions/discharge Pelvic Inflammatory Disease Abnormal pap smear Irregular periods Painful menstrual periods Premenstrual syndrome Abnormal bleeding Menopausal syndrome Breast lumps Other
SKIN	RESPIRATORY	MALE
past current Rashes Hives Itching Eczema Pimples Dryness Tumors, lumps Changes in moles or lumps Bruise easi	past current Asthma or Wheezing Bronchitis Frequent colds Chronic Pulmonary Disease Pneumonia Cough Coughing blood Production of phlegm Oter	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 Oter	past current Infection Ringing Decreased hearing Oter	past current Seizures Tremors Numbness or tingling of limbs Concussion Pain Paralysis Oter
EYES	GENITO-URINARY	NOSE, THROAT AND MOUTH

past current Blurred vision Visual changes Poor night vision Spots Glasses/Contacts Eye inflammation Oter	past current Kidney stones Pain on urination Frequent urination Blood in urine Urgency to urinate Unable to hold urine Oter	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
GASTRO-INTESTNAL	PYSCHOLOGICAL	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