Matrix of Holistic Health
Janina Ward- Traditional Naturopath
928-713-5617

PATIENT INTAKE FORM

Patient Name: _____ Date:_____

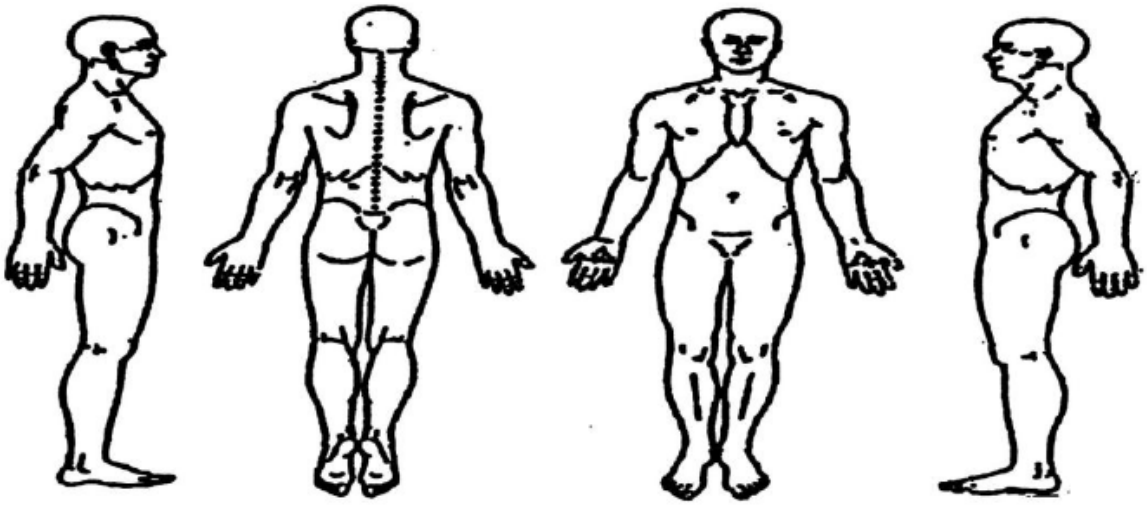
Address:_____City_____State_____Zip Code_____

Phone_____email_____

Date of birth_____

In case of emergency, notify: _____

1. Indicate on the drawings below where you have pain/symptoms if no pain symptoms skip to question # 4.



2. How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)

□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

3. How would you describe the type of pain?

□ Sharp □ Achy □ Stiff □ Sharp with motion

□ Dull □ Burning □ Numb □ Shooting with motion

□ Diffuse □ Shooting □ Tingly □ Stabbing with motion

□ Other _____ □ Electric like with motion

4. Do you have any digestive issues, indigestion, constipation, frequent diarrhea etc? if so which one _____.

5. Do you have daily bowel movements? Yes/ No

6. Are your hands and feet frequently cold? Yes/No

7. Do you get sick often? Yes/No

8. How many hours of sleep do you get a night? _____

Please check or circle any of the following symptoms you have recently experienced:

Energy Level and Sleep:

- Chronic fatigue
- Less stamina than others
- Long recovery period after any activity
- Inability to concentrate
- Sleep apnea
- Snoring
- Insomnia
- Need naps in the afternoon
- Weakness
- Wake feeling tired
- Frequently oversleep

Weight:

- Weight gain
- Inability to lose weight
- Abdominal fluid retention
- Metabolic Syndrome

Body Temperature:

- Cold extremities
- Cold sweats
- Night sweats
- Heat intolerance
- Cold intolerance
- Internal shivering
- Hypothermia
- Cold hands
- Clammy palms
- Cold feet
- Excessive perspiration
- Little perspiration
- Low basal body temperature (below 97.8 degrees Fahrenheit)

Mouth and Throat:

- Difficulty swallowing
- Sensation of lump in throat
- Sensation of pressure on throat
- Pain and tenderness in neck and/or thyroid area
- Difficulty taking deep breath
- Goiter
- Thyroid nodule
- Burning sensation in throat
- Sore throats
- Swollen tongue
- Choking fits
- Distorted sense of taste (Dysgeusia)
- Salt cravings

- Sweet cravings
- Speech problems
- Dry mouth
- Halitosis (bad breath)
- Propensity for cavities
- Propensity for gum disease
- Low, husky, hoarse voice
- Bleeding gums
- Receding gums
- Irritated gums
- Swollen gums
- Persistent teeth clenching
- TMJ

Ears:

- Oversensitive hearing
- Noises in ears (hissing, ringing)
- Deafness
- Tinnitus
- Internal itching of ears
- Dry, scaly ear canal
- Excess earwax
- Vertigo

Eyes:

- Poor focusing
- Double vision
- Dry eyes
- Gritty eyes
- Achy eyes
- Blurred vision
- Drooping eyelids
- Sensitive to light
- Frequent tics in the eyes
- Spasms of the eyelids
- Bulging of the eyeballs

- Red inflamed eyes
- Dark rings under eyes
- Puffiness around the eyes
- Rapidly shifting gaze making you feel dizzy
- Problems with night vision
- Glaucoma
- Cataracts

Hair:

- Hair loss
- Dry hair
- Frizzy hair
- Brittle hair
- Coarse hair
- Finer hair
- Premature baldness
- Premature gray hair
- Change in hair texture
- Body hair loss
- Eyelash loss
- Facial hair in women
- Thinning or loss of outside third of eyebrows

Nails:

- Brittle
- Pale
- Soft
- Yellowish
- Ridged
- Striated
- Thickened
- Ingrown toenails

Skin:

- Dry skin
- Dry itchy scalp

- Flaky skin
- Cracked heels
- Coarse patches
- Yellowish or amber tint to their skin
- Dry mucous membranes
- Pale skin
- Pale lips
- Boils
- Pigmentation in skin creases
- Rashes
- Skin tags
- Eczema
- Chronic itching
- Varicose veins
- Allergies
- Hives

Numbness and Tingling:

- Legs
- Feet
- Arms
- Hands
- Back
- Face
- Painful soles of feet
- Muscle cramps
- Aching bones
- Aching muscles
- Joint pain
- TMJ
- Fibromyalgia
- Protruding abdomen in children
- Diverticulosis
- Excess gas
- Flatulence
- Nausea

- Ulcers
- Acid Reflux
- Excessive belching
- GERD (Gastroesophageal Reflux Disease)

Menstrual Disorders:

- Cessation of periods (amenorrhoea)
- Scanty (light) periods (oligomenorrhoea)
- Heavy periods (menorrhagia)
- Irregular periods
- Severe cramping
- Failure to ovulate
- Constant bleeding
- Premenstrual syndrome (PMS)
- Premenstrual tension (PMT)
- Difficult menopause
- Hysterectomy
- Endometriosis
- Ovarian fibroids
- Polycystic ovary syndrome (PCOS)

Accident and surgical history:

Please list any surgeries:_____

_____

_____

_____

_____

_____

_____.

Have you had any broken bones, or other physical or emotional traumas? Please list those you are comfortable sharing and approximate dates.

_____

_____

_____

_____

_____

_____

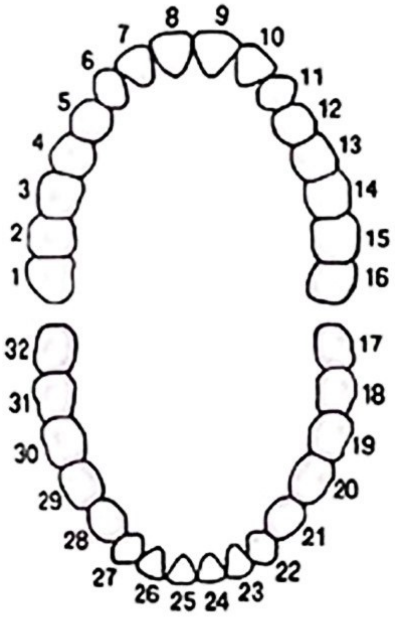
Denta l History very important, please do not skip this section:

1. Do you have any root canals? Yes/No
2. Do you have any silver fillings? Yes/No
3. Do you have any dental infections? Yes/No
4. When is the last time you had a dental exam? _____.

On the chart below please circle any teeth you have had a root canal on. Please put an X on any teeth with silver fillings or that you have had problems with, infections etc.

Upper Right:

1: 3rd Molar (wisdom tooth)
2: 2nd Molar (12-year molar)
3: 1st Molar (6-year molar)
4: 2nd Bicuspid (2nd premolar)
5: 1st Bicuspid (1st premolar)
6: Cuspid (canine/eye tooth)
7: Lateral incisor
8: Central incisor



Upper Left:

9: Central incisor
10: Lateral incisor
11: Cuspid (canine/eye tooth)
12: 1st Bicuspid (1st premolar)
13: 2nd Bicuspid (2nd premolar)
14: 1st Molar (6-year molar)
15: 2nd Molar (12-year molar)
16: 3rd Molar (wisdom tooth)

Lower Right:

25: Central incisor
26: Lateral incisor
27: Cuspid (canine/eye tooth)
28: 1st Bicuspid (1st premolar)
29: 2nd Bicuspid (2nd premolar)
30: 1st Molar (6-year molar)
31: 2nd Molar (12-year molar)
32: 3rd Molar (wisdom tooth)

Lower Left:

17: 3rd Molar (wisdom tooth)
18: 2nd Molar (12-year molar)
19: 1st Molar (6-year molar)
20: 2nd Bicuspid (2nd premolar)
21: 1st Bicuspid (1st premolar)
22: Cuspid (canine/eye tooth)
23: Lateral incisor
24: Central incisor

For the specific issues that are of concern for your appointment today:

1. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

2. Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Massage Therapist □ Primary Care Physician □ No one

□ ER physician □ Orthopedist □ Physical Therapist □ Other:_____

3. How long have you had this problem?

_____

4. How do you think your problem began?

_____

5. Do you consider this problem to be severe? □ Yes □ Yes, at times □ No

6. What aggravates your problem?

_____

13. What concerns you the most about your problem; what does it prevent you from doing?

_____

14. What is your: Height_____ Weight _____ Date of Birth _____

Occupation or previous occupation if

retired_____

19. Why do you think other doctors have not been able to help you achieve you

goals?_____

_____

_____

20. What are you most concerned with regarding your problem?_____

_____

_____

23. What do you desire most to get from this appointment?

_____

_____

_____

24. What do you think is a realistic time frame for you to see some improvement under our care?

_____

Medications

Please list all drugs you are currently taking including over the counter drugs, aspirin, etc. Also list how long you have taken each drug and the condition for which it was prescribed.

DRUG PRESCRIBED FOR: DATE STARTED TAKING

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Please list all vitamins/herbs/supplements you are currently taking. Also, list how much of each supplement and why you are taking it.

VITAMIN REASON HOW MUCH

_____

_____

_____

_____

_____

_____

Please type a detailed timeline of your medical history and return with this form.

Please include:

□The main problems/concerns or symptoms that you are experiencing. List them.

□When did these problems start? How have they changed over time?

□What have you tried to help this? (Medications, therapies, diet, supplements, etc.)

□What was the response? (helped, worse, no change)

□What do you think makes these symptoms worse?

□What do you think makes these symptoms better?

□TELL ME AS MUCH AS YOU CAN!

Please list the 5 major health concerns in your order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

Has there been any diagnosis of your symptoms/conditions? □ Yes □ No

If yes, please list the diagnosis, who made the diagnosis and the date diagnosis was made:

_____

Please bring any lab reports or copies of medical records to your appointment if possible. While Naturopath's do not "treat" lab results, lab results often mean different things to a Naturopath than they do to a conventional medical doctor and just because your labs may be in the "normal" range, the levels can be indicative of disorders that Naturopath's view differently than conventional medicine.

I acknowledge that I am aware that Janina Ward is not a licensed medical doctor and therefore cannot diagnose or prescribe medications. Janina Ward is a Traditional Naturopath and Holistic Healthcare Provider licensed by the Pastoral Medical Association. All recommendations and therapies provided are designed to bring your body, mind and spirit back to its natural alignment so as to facilitate healing from within. Many therapies are designed to remove toxins of environmental, emotional, energetic and spiritual in nature.

Patient Signature_____ date_____

What is Naturopathy?

Naturopathy is the earliest known healing system that uses natural forces such as water, air, sunlight, earth's magnetic fields, exercise, rest, proper diet, mechanical treatments and mental and biological science. Naturopath's practice and believe in the healing power of nature. This belief encompasses the concept that the body can heal itself of nearly anything if it is cleared of toxins, deficiencies and has the proper nutrition, rest, and natural stimulation. Causation is more important than symptoms in holistic healing but symptoms are indications of the cause.