Dr. Alyson Mather, DC

Initial Intake Form

PATIENT INFORMATION

Name: _____ Birthday (M/D/Y): _____ Age: _____ Gender: _____

Height: _____ Weight: _____

Address: _____

(Street) (City) (Postal Code)

Home Ph. #: _____ Cell: _____ Email: _____

Marital status: _____ # of Children: _____ Occupation: _____

Do you wish to receive Journey of Health's E-Newsletter? Y/ N

Can Journey of Health use your email address to contact you concerning your care? Y/N

How did you hear about this clinic: ☐ Walk by ☐ Website ☐ Flyer

☐ Referral: _____ ☐ Newspaper ☐ Other: _____

Name of Medical Doctor: _____ Permission to contact for labs, etc. Y/N

MAIN HEALTH CONCERNS

My usual health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please list, in order of importance, your chief concerns:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

FAMILY & PERSONAL HISTORY

Please list family members (or yourself) who have the following conditions:

Cancer:	Autoimmune disease:
Eczema:	Arthritis:
Diabetes:	Allergies:
Heart disease:	Asthma:

Initial Intake Form

High blood pressure:	Addictions:
Stroke:	Liver disease:
Thyroid disease:	Mental illness:

Please list hospitalizations, surgeries, major accidents/injuries, x-rays, CAT scans, MRIs, EKGs, etc.

Year: _____ Description: _____

Year: _____ Description: _____

Year: _____ Description: _____

Year: _____ Description: _____

Major mental/emotional traumas: (loss of loved one, divorce, career change, miscarriage, major disease, etc.)

_____

List any real or suspected allergies/sensitivities to drugs, food, alcohol, caffeine, chemicals, perfumes, smoke, environment, or other: _____

_____

Please list supplements you are currently taking:

1. _____ (Brand) (Supplement Name) (Daily Dose)
2. _____ (Brand) (Supplement Name) (Daily Dose)
3. _____ (Brand) (Supplement Name) (Daily Dose)
4. _____ (Brand) (Supplement Name) (Daily Dose)
5. _____ (Brand) (Supplement Name) (Daily Dose)
6. _____ (Brand) (Supplement Name) (Daily Dose)
7. _____ (Brand) (Supplement Name) (Daily Dose)
8. _____ (Brand) (Supplement Name) (Daily Dose)
9. _____ (Brand) (Supplement Name) (Daily Dose)
10. _____ (Brand) (Supplement Name) (Daily Dose)

Read the following questions and fill in the number that applies:

0 (leave blank) = Never consume or use
1 = Consume or use several times per month
2 = Consume or use weekly
3 = Consume or use daily

Initial Intake Form

DIET

____ Alcohol
____ Pop/soda
____Coffee
__ _____ Black tea
_____ Water
____ Tobacco products
_____Past tobacco use?

LIFESTYLE

_____ Exercise (3 = 5+ times per week, 2 = 2-4 times per week, 1 = once per week, 0 = none)
_____ Stress (3 = heavy/chronic, 2 = moderate/often stressed, 1 = light/occasionally stressed, 0 = none)
_____ Changed jobs (3 = within last 2 months, 2 = within last 6 months, 1 = within last 12 months)
_____ Divorced (3 = within last 6 months, 2 = within last year, 1 = within last 2 years, 0 = never)
_____ Work over 40 hours/week (3 = always, 2 = usually, 1 = occasionally, 0 = never)

MEDICATIONS

Indicate with a check mark any medications you're currently taking or have taken in the past month:

_____ Antacids
_____ Antibiotics
_____ Anticonvulsants
_____ Antidepressants
_____ Antifungals
_____ Aspirin/Ibuprofen
_____ Asthma inhalers
_____ Beta blockers
_____ Birth control
_____ Chemotherapy
_____ Cortisone
_____ Diabetic medications
_____ Diuretics
_____ Heart medications
_____ High blood pressure
_____ Hormone Therapy
_____ Laxatives
_____ Insulin
_____ Recreational drugs
_____ Relaxants/Sleeping pills
_____ Thyroid medication
_____ Tylenol/acetaminophen
_____ Ulcer medications
OOther: _____

Read the following questions and circle the number that applies:

0 (leave blank) = Do not experience
1 = Minor or mild symptom, or it rarely occurs (once a month or less)
2 = Moderate symptom or it occasionally occurs (weekly)
3 = Severe symptom or it frequently occurs (daily or almost daily)

UPPER GASTROINTESTINAL SYSTEM

Belching or gas within 1 hr. of a meal	0 1 2 3
Heartburn or acid reflux	0 1 2 3
Bloating shortly after eating	0 1 2 3
Are you a vegan	No Yes
Bad breath	0 1 2 3
Loss of taste for meat	0 1 2 3
Sweat has a strong odor	0 1 2 3
Nausea from taking vitamins	0 1 2 3
Sense of excess fullness after meals	0 1 2 3
Do you feel like skipping breakfast?	0 1 2 3
Do you feel better if you don't eat?	0 1 2 3
Sleepy after meals	0 1 2 3
Fingernails chip, peel or break easily	0 1 2 3
Anemia unresponsive to iron	0 1 2 3
Stomach pains or cramps	0 1 2 3
Diarrhea, chronic	0 1 2 3
Diarrhea shortly after meals	0 1 2 3
Black or tarry stools	0 1 2 3
Undigested food in stool	0 1 2 3

LIVER/GALLBLADDER

Pain between shoulder blades	0 1 2 3
Stomach upset by greasy foods	0 1 2 3
Greasy or shiny stools	0 1 2 3
Nausea	0 1 2 3
Motion sickness (air, car, boat)	0 1 2 3
History of morning sickness (pregnancy)	No Yes
Light or clay colored stools	0 1 2 3
Dry skin, itchy feet or skin peels on feet	0 1 2 3
Headache over the eye	0 1 2 3
Gallbladder attacks (past or present)	0 1 2 3
Gallbladder removed	No Yes
Bitter taste in mouth, esp. after meals	0 1 2 3
Become sick if drinking wine	0 1 2 3
If drinking alcohol, easily intoxicated	0 1 2 3
Alcoholic beverages per week	0 1 2 3
Recovering alcoholic	No Yes
Hangovers after drinking alcohol	0 1 2 3
History of drug or alcohol abuse	No Yes
History of hepatitis	No Yes
Long term use of Rx medications	No Yes

Sensitive to chemicals (perfume, etc.)	0 1 2 3
Sensitive to tobacco smoke	0 1 2 3
Exposure to diesel fumes	0 1 2 3
Pain under right side of rib cage	0 1 2 3
Hemorrhoids or varicose veins	0 1 2 3
Nutrasweet (aspartame) consumption	0 1 2 3
Bothered by aspartame	0 1 2 3
Chronic fatigue syndrome or fibromyalgia	0 1 2 3

SMALL INTESTINE

Food allergies	0 1 2 3
Abdominal bloating 1-2 hrs after eating	0 1 2 3
Specific foods cause fatigue or bloating	0 1 2 3
Pulse speeds after eating	0 1 2 3
Airborne allergies	0 1 2 3
Experience hives	0 1 2 3
Sinus congestion, "stuffy head"	0 1 2 3
Crave bread or pasta	0 1 2 3
Alternating constipation and diarrhea	0 1 2 3
Crohn's disease	No Yes
Wheat or grain sensitivity	0 1 2 3
Dairy sensitivity	0 1 2 3
Are there foods you could not give up?	No Yes
Asthma, sinus infections, stuffy nose	0 1 2 3
Bizarre, vivid or nightmarish dreams	0 1 2 3
Use over-the-counter pain medications	0 1 2 3
Feel spacey or unreal	0 1 2 3

LARGE INTESTINE

Anus itches	0 1 2 3
Coated tongue	0 1 2 3
Feel worse in moldy or musty places	0 1 2 3
Taken an antibiotic for a length of time of 1 = < 1 mo, 2 = < 3 mos., 3 = > 3 mos.	0 1 2 3
Fungus or yeast infections	0 1 2 3
Ring worm, "jock itch", athlete's foot, or nail fungus	0 1 2 3
Eating sugar, starch or drinking alcohol increases yeast symptoms	0 1 2 3
Stools hard or difficult to pass	0 1 2 3
History of parasites	No Yes
Less than one bowel movement every day	No Yes
Stools have corners, or edges are flat and/or ribbon shaped	0 1 2 3
Stools are not well formed (loose)	0 1 2 3
Irritable bowel syndrome	0 1 2 3
Blood in stool	0 1 2 3
Mucus in stool	0 1 2 3
Excessive foul smelling gas	0 1 2 3
Bad breath or strong body odor	0 1 2 3
Painful to press outer sides of thighs	0 1 2 3
Cramping in lower abdomen	0 1 2 3

MINERAL NEEDS

History of carpal tunnel syndrome	No Yes	Bone loss (reduced density on bone scan)	0 1 2 3
History of lower right abdominal pain	No Yes	Are you shorter than you used to be?	No Yes
History of stress fractures	No Yes	Calf, foot or toe cramps at rest	0 1 2 3

Cold sores, blisters or herpes lesions	0 1 2 3
Frequent fevers	0 1 2 3
Frequent skin rashes and/or hives	0 1 2 3
Have you ever had a herniated disc?	No Yes
Excessively flexible joints/double jointed	0 1 2 3
Joints pop or click	0 1 2 3
Pain or swelling in joints	0 1 2 3
Bursitis or tendonitis	0 1 2 3
History of bone spurs	No Yes
Morning stiffness	0 1 2 3
Vomiting or nausea	0 1 2 3
Crave chocolate	0 1 2 3
Feet have a strong odor	0 1 2 3
Tendency to anemia (low red blood cells)	0 1 2 3
Whites of eyes (sclera) are tinted blue	0 1 2 3
Hoarseness of voice	0 1 2 3
Difficulty swallowing	0 1 2 3
Lump in throat	0 1 2 3
Dry mouth, eyes and/or nose	0 1 2 3
Gag easily	0 1 2 3
White spots on fingernails	0 1 2 3
Cuts heal slowly and/or scar easily	0 1 2 3
Decreased sense of taste or smell	0 1 2 3

ESSENTIAL FATTY ACIDS

Aspirin is an effective pain reliever	No Yes
Crave fatty or greasy foods	0 1 2 3
Low or reduced-fat diet (past or present)	0 1 2 3
Tension headaches at base of skull	0 1 2 3
Headaches when out in the hot sun	0 1 2 3
Sunburn easily or suffer sun stroke	0 1 2 3
Muscles become easily fatigued	0 1 2 3
Dry, flaky skin and/or dandruff	0 1 2 3

SUGAR HANDLING

Awaken a few hours after falling asleep, and difficulty getting back to sleep	0 1 2 3
Crave sweets	0 1 2 3
Eat desserts or sugary snacks	0 1 2 3
Binge or uncontrolled eating	0 1 2 3
Excessive appetite	0 1 2 3
Crave coffee or sugar in the afternoon	0 1 2 3
Sleepy in afternoon	0 1 2 3
Fatigue that is relieved by eating	0 1 2 3
Headache if meals are skipped or delayed	0 1 2 3
Irritable when skipping meals	0 1 2 3
Shaky if meals are delayed	0 1 2 3
Family members with diabetes 0 = 0 1 = 2 or less, 2 = 2 – 4, 3 = More than 4	0 1 2 3
Frequent thirst	0 1 2 3
Frequent urination	0 1 2 3

VITAMIN NEEDS

Muscles become easily fatigued	0 1 2 3
Feel worse or sore after exercise	0 1 2 3
Vulnerable to insect bites	0 1 2 3
Heaviness in arms/legs	0 1 2 3
Enlarged heart, or heart failure	0 1 2 3
Pulse slow (< 65 beats per minute)	No Yes
Ringing in ears	0 1 2 3
Numbness, tingling or itching in extremities	0 1 2 3
Depressed	0 1 2 3
Fear of impending doom	0 1 2 3
Worrier, apprehensive, anxious	0 1 2 3
Nervous or agitated	0 1 2 3
Feelings of insecurity	0 1 2 3
Heart races	0 1 2 3
Can hear heart beat on pillow at night	0 1 2 3
Body or limb jerks when falling asleep	0 1 2 3
Night sweats	0 1 2 3
Restless leg syndrome	0 1 2 3
Cracks or cuts at corner of mouth	0 1 2 3
Fragile skin, easily chaffed (ie. shaving)	0 1 2 3
Polyps or warts	0 1 2 3
MSG sensitivity	0 1 2 3
Can't remember dreams on waking	0 1 2 3
Taking the birth control pill	0 1 2 3
Small bumps on back of upper arms	0 1 2 3
Strong light at night irritates eyes	0 1 2 3
Nose bleeds and/or easy bruising	0 1 2 3
Bleeding gums (ie. when brushing teeth)	0 1 2 3

ADRENAL GLAND

Tend to be a "night person"	0 1 2 3
Difficulty falling asleep	0 1 2 3
Slow starter in the morning	0 1 2 3
Keyed up, trouble calming down	0 1 2 3
High blood pressure (normal = 110/70)	0 1 2 3
Headache after exercising	0 1 2 3
Feeling wired or jittery with coffee	0 1 2 3
Clench or grind teeth	0 1 2 3
Calm on the outside, troubled inside	0 1 2 3
Chronic low back pain, worse tired	0 1 2 3
Become dizzy/faint upon standing	0 1 2 3
Difficult maintaining a chiropractic adjustment	0 1 2 3
Pain after manipulative correction	0 1 2 3
Arthritic tendencies	0 1 2 3
Crave salty foods	0 1 2 3
Salt foods before tasting	0 1 2 3
Perspire easily	0 1 2 3
Chronic fatigue, or get drowsy often	0 1 2 3
Afternoon yawning	0 1 2 3
Afternoon headache	0 1 2 3
Asthma, wheezing or difficulty breathing	0 1 2 3
Pain on the inner side of the knee	0 1 2 3
Tendency to sprain ankles or develop "shin splints"	0 1 2 3
Tendency to require sunglasses	0 1 2 3
Allergies and/or hives	0 1 2 3
Weakness, dizziness	0 1 2 3
Easily stressed out	0 1 2 3

PITUITARY GLAND

Over 6’6" tall	0 1 2 3
Early sexual development (< age 10)	No Yes
Increased libido	0 1 2 3
Splitting type headache	0 1 2 3
Memory failing	0 1 2 3
Ability to tolerate sugar; fine with eating	0 1 2 3
Under 4’10" (mature height)	0 1 2 3
Decreased libido	0 1 2 3
Abnormal thirst	0 1 2 3
Weight gain around hips or waist	0 1 2 3
Menstrual disorders	0 1 2 3
Delayed sexual development (> age 13)	No Yes
Tendency to have ulcers or colitis	0 1 2 3

THYROID

Allergic to iodine	0 1 2 3
Difficulty gaining weight	0 1 2 3
Nervous, emotional, or can’t work under pressure	0 1 2 3
Inward trembling	0 1 2 3
Flush easily	0 1 2 3
Fast pulse at rest	0 1 2 3
Intolerance to high temperatures	0 1 2 3
Difficulty losing weight	0 1 2 3
Mentally sluggish, lacking motivation	0 1 2 3
Easily fatigued, sleepy during the day	0 1 2 3
Cold hands and feet, poor circulation	0 1 2 3
Chronic constipation or sluggish digestion	0 1 2 3
Excessive hair loss and/or coarse hair	0 1 2 3
Morning headaches, fade with time	0 1 2 3
Loss of outside 1/3 of eyebrow	0 1 2 3
Seasonal sadness	0 1 2 3

MEN ONLY

Prostate problems	0 1 2 3
Urination difficult or dribbling	0 1 2 3
Difficult to start and stop urine stream	0 1 2 3
Pain or burning with urination	0 1 2 3
Waking to urinate at night	0 1 2 3
Interruption of stream during urination	0 1 2 3
Pain on inside of legs or heels	0 1 2 3
Feeling of incomplete bowel evacuation	0 1 2 3
Decreased sexual function	0 1 2 3
History of sexually transmitted infections	No Yes

WOMEN ONLY

Depression during periods	0 1 2 3	Crave chocolate around periods	0 1 2 3
Premenstrual syndrome (PMS)	0 1 2 3	Breast tenderness associated with cycle	0 1 2 3

Excessive menstrual flow	0 1 2 3
Scanty blood flow during periods	0 1 2 3
Occasional skipped periods	0 1 2 3
Variations in menstrual cycles	0 1 2 3
Endometriosis	0 1 2 3
Uterine fibroids	0 1 2 3
Breast fibroids, benign masses	0 1 2 3
Painful intercourse (dyspareunia)	0 1 2 3
Vaginal discharge	0 1 2 3
Vaginal dryness	0 1 2 3
Vaginal itchiness	0 1 2 3
Weight gain around hips, thighs and buttocks	0 1 2 3
Excess facial or body hair	0 1 2 3
Thinning skin	0 1 2 3
Hot flashes	0 1 2 3
Night sweats (in menopausal females)	0 1 2 3
Pregnant	No Yes
History of sexually transmitted infections	No Yes
Difficulty conceiving/infertility	No Yes

CARDIOVASCULAR

Aware of heavy and/or irregular breathing	0 1 2 3
Discomfort at high altitudes	0 1 2 3
"Air hunger" and/or yawn frequently	0 1 2 3
Compelled to open windows in a closed room	0 1 2 3
Shortness of breath with exertion	0 1 2 3
Ankles swell, especially at end of day	0 1 2 3
Cough at night	0 1 2 3
Blush or face turns red for no reason	0 1 2 3
Dull pain or tightness in chest, possibly radiates into arm, worse w/exertion	0 1 2 3
Muscle cramps with exertion	0 1 2 3

KIDNEY & BLADDER

Pain in mid back region	0 1 2 3
Dark circles under eyes and/or puffy eyes	0 1 2 3
History of kidney stones	No Yes
Cloudy, bloody or darkened urine	0 1 2 3
Urine has a strong odor	0 1 2 3

IMMUNE SYSTEM

Runny or drippy nose	0 1 2 3
Catch colds at the beginning of winter	0 1 2 3
Mucus-producing cough	0 1 2 3
Frequent infections (ear, sinus, lung, skin, bladder, kidney, etc.)	0 1 2 3
Frequent colds or flu	0 1 2 3
Never get sick (3 = not in last 7 yrs,	

2 = not in last 4 yrs, 1 = not in last 2 yrs)	0	1	2	3
Acne (adult)	0	1	2	3
Itchy skin/dermatitis	0	1	2	3
Cysts, boils, rashes	0	1	2	3
History of viruses: Epstein Bar, mono, herpes, shingles, chronic fatigue, hepatitis	0	1	2	3

PSYCHOLOGICAL

Treated for emotional issues	0	1	2	3
Depression	0	1	2	3
Anxiety/nervousness	0	1	2	3
Poor concentration	0	1	2	3
Mood swings	0	1	2	3
Ever considered suicide	0	1	2	3
Ever attempted suicide	0	1	2	3

Informed Consent and Request for Naturopathic Medical Care and Acupuncture

As a patient, I have the right to be informed about my health condition(s) and recommended treatments. Dr. Alyson Mather will discuss the potential benefits, risks and hazards involved. After signing this consent form, I understand I can withdraw consent at any time.

I recognize that even the gentlest therapies may potentially have complications in very young children, in the elderly, or in those on multiple medications. Hence, the information I have provided is complete and inclusive of all health concerns and medications, including over-the-counter medications, supplements, and herbs.

I give my written consent for evaluation and treatment. I intend this as a consent form to cover my entire course of treatments including any future conditions for which I seek treatment.

_____ _____ _____

Printed Name Signature Date