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## Screening Intake Form

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*Welcome to Our Healing Roots, LLC! We are glad you found us. Initial consults are an investment of time and money, so we want to make sure that we are likely a good fit for you before that investment is made. Katrina Bogdon, ND, will review each form prior to scheduling. Please allow 48-72 business hours for a response. If you have questions about our services or need to speak to Katrina Bogdon, ND, prior to or while filling out this form, please contact the front desk at 417-883-5180.*

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### Contact Information

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

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

If under 18, guardian's name(s): \_\_\_\_\_

What name do you prefer to be called? \_\_\_\_\_

Complete Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Alternate phone: \_\_\_\_\_

E-mail address: \_\_\_\_\_

How do you prefer us to contact you? \_\_\_\_\_

Is it okay to leave a voice message? \_\_\_\_\_ Is it okay to send an e-mail? \_\_\_\_\_

Do you want to use the patient online portal for our office?  Yes  No

Do you want to receive e-mails about news, upcoming events & specials?  Yes  No

Emergency Name & Contact Number: \_\_\_\_\_

Current Health Care Providers: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Are there family members, close friends, or others involved in your care with whom you wish for us to share your health information upon request? \_\_\_\_\_

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## Initial Screening Questions

1. Are you diagnosed with cancer AND seeking to use natural therapies *in place of* a prescribed conventional cancer treatment by a licensed oncologist? Yes No
2. Are you needing Katrina Bogdon to write drug or hormone prescriptions?
3. Are you seeking to stop a prescribed drug *without* your prescribing physicians support and direction? Yes No
4. Are you seeking a vaccination exemption letter or form from Katrina Bogdon? Yes No
5. Are you seeking a medical diagnosis from Katrina Bogdon? Yes No
6. Do you intend to file these services with an insurance company (requiring diagnosis codes)? Yes No
7. Would you be depending on Katrina Bogdon to be available to you outside of normal business hours (i.e. available to call on weekends and nights)? Yes No
8. Are you seeking care for an infant (less than 12 months)? Yes No

***If you answered “Yes” to any of the questions above, please stop here. Our Healing Roots, LLC, is not able to provide these services.***

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9. Are you using a particular program with which you expect Katrina Bogdon to be familiar (i.e. reading a health book and wanting Katrina Bogdon to use that program with you)? If yes, please name the program(s) below.

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10. Do you have any special needs or considerations that need to be met while providing care for you? (i.e. medical anxiety, difficulty swallowing, chemical sensitivity, adverse reactions to many supplements)

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## Health History

For what concerns are you presenting here?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Other Current Medical Diagnoses

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Past Surgeries and Traumatic Injuries

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Allergies & Intolerances

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## Family Medical History

*Please describe any known medical conditions your biological family members listed below have had.*

Mother: \_\_\_\_\_

Maternal Grandparents: \_\_\_\_\_

Father: \_\_\_\_\_

Paternal Grandparents: \_\_\_\_\_

Siblings: \_\_\_\_\_

Other (i.e. aunts/uncles): \_\_\_\_\_



# Review of Systems

## HEAD

- Headaches
- Visual Disorder
- Watery, itchy, or dry eyes
- Sensitivity to light
- Sinus problems
- Dental problems
- Hearing Loss
- Ringing in the ears
- Earache
- Light-headed/dizzy

## RESPIRATORY

- Asthma, bronchitis
- Hoarseness
- Emphysema
- Pneumonia
- Tuberculosis
- Shortness of breath
- Chronic cough

## GASTROINTESTINAL

- Reflux/Ulcers
- Sore throat/difficulty swallowing
- Inflammatory Bowel Disorder
- Hepatitis
- Gallbladder disease
- Constipation
- Abdominal pain
- Diarrhea
- Nausea/Vomiting
- Gas/Bloating

## CARDIOVASCULAR

- High blood pressure
- Elevated cholesterol
- Heart disease
- Arrhythmia/Murmur/Palpitations
- Chest pain
- Heart Attack
- Stroke

## MUSCULOSKELETAL

- Back Pain
- Carpal Tunnel Syndrome
- Gout
- Osteoporosis
- Joint pain or stiffness

## SKIN

- Acne
- Itching
- Rashes, cysts, warts
- Easy bruising
- Swelling/edema
- Eczema/Psoriasis
- Dry skin
- Varicose veins
- Hair loss/changed texture
- Nail changes

## ENDOCRINE

- Chronic Fatigue
- Diabetes
- Thyroid Disorder
- Weight loss/gain
- Change in thirst/appetite
- Overly cold or hot

## MENTAL/EMOTIONAL

- Depression
- Anxiety
- Anger management
- Grief
- Drug addiction
- Eating disorder
- Learning disorder
- Alcoholism
- ADD/ADHD

## IMMUNE/BLOOD

- Clotting disorder
- Chronic infection
- Slow wound healing
- Anemia

## MALE REPRODUCTIVE

- Enlarged Prostate
  - Sexually active
  - Decreased sex drive
  - Infertility
  - STD
- | Type  | Date Diagnosed |
|-------|----------------|
| _____ | _____          |

Date of last prostate exam:  
\_\_\_\_\_

## FEMALE REPRODUCTIVE

- Menstrual irregularities
  - Endometriosis
  - Fibrocystic breasts
  - Fibroids/ovarian cysts
  - PCOS
  - Premenstrual syndrome
  - Menopausal symptoms
  - Breast Lumps
  - Vaginal infections
  - Decreased sex drive
  - Urinary Tract Infection
  - STD
- | Type  | Date Diagnosed |
|-------|----------------|
| _____ | _____          |

- Abnormal PAP
- Sexually active
- Use of birth control
- Currently Pregnant
- Post-menopausal
- Surgical Menopause
- # of pregnancies \_\_\_
- # of children \_\_\_
- Age of first period? \_\_\_
- Date of Last Menstrual cycle:  
\_\_\_\_\_

Length of cycle (i.e. 28 days):  
\_\_\_\_\_

Date of last GYN exam:  
\_\_\_\_\_

**NERVOUS SYSTEM**

- Poor concentration/memory
- Neuropathy or Paralysis
- Seizures
- Dementia
- Multiple Sclerosis
- Restless Legs

**CANCER**

Type \_\_\_\_\_ Date \_\_\_\_\_

**URINARY**

- Kidney or Bladder Disease
- Incontinence
- Frequent or painful urination
- Kidney stones

**OTHER**

**OTHER**

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**Lifestyle History**

Tobacco:  Never used  Used, but quit  Currently using

Alcohol:  Never used Frequency: \_\_\_\_\_

Recreational Drugs:  Never used  Used, but quit  Currently using

Are you currently having thoughts of harming yourself or others?  Yes  No

Occupation:  Student  Retired  Disabled  Employed

If employed or student, please describe what you do or study: \_\_\_\_\_

What do you love to do (i.e. hobbies)? \_\_\_\_\_

Who do you live with? \_\_\_\_\_

Do you have difficulty  Falling asleep  Staying asleep  Waking early  Waking refreshed

How many times do you eat each day? \_\_\_\_\_

How many hours do you sleep? \_\_\_\_\_

What have you eaten and drank in the past 24 hours (or on a typical day)? \_\_\_\_\_

Are there any foods you avoid? \_\_\_\_\_

What type of regular movement/exercise do you engage in? \_\_\_\_\_

How would you rate the level of stress in your life (0-10, 10 highest)? \_\_\_\_\_

How do you rate your energy level (0-10, 10 best)? \_\_\_\_\_

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Have you ever worked with a naturopathic or integrative doctor before? If so, what worked well and what did not work well for you? \_\_\_\_\_

Is there any other information you would like to share that wasn't asked?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Feel free to include additional information if you didn't have enough space. Please take a moment to look within your life. What needs to change in your life for you to be truly healthy, not just free of disease? Naturopathic healthcare will not be a quick fix. In meeting with Katrina Bogdon, she will act as a consultant and give you recommendations that may impact your lifestyle, your daily schedule, and what you take. Are you at a good time and place in your life to make this type of change right now? If you are ready, please return this form to Our Healing Roots, LLC. If you are not ready quite yet, it's okay. Take your time and feel welcome to wait until the time is right for you.*