Phone: 417-894-3611
417-319-3081
Fax: 1-844-685-0298
www.ourhealingroots.net
office@ourhealingroots.net
760 Short State Hwy P
Seymour, MO 65746

Screening Intake Form

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 us at the number listed above.

Contact Information

Today's Date: ______________________
Name: _______________________________________ Birthdate: ____________
If under 18, guardian's name(s): ____
Name you prefer: _______________________ Gender: ____________________
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
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?______________________
____

Our Healing Roots, LLC is owned and operated by Katrina Bogdon, ND. 2BWell houses several separate wellness-focused businesses, providing them space and a wide range of services. 2BWell is NOT owned and operated by Katrina Bogdon, ND. Do you want to receive e-mails about news, upcoming events & specials…

From Our Healing Roots, LLC? ☐ Yes ☐ No
From 2BWell? ☐ Yes ☐ No

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? ☐Yes ☐No
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.

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.

____

____

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)

____

____

____

11. For your health privacy, we can NOT use text messaging or social media messaging systems to communicate with clients. Do you consent not to send us messages this way? Yes No

Health History

For what concerns are you presenting here?

1. ____
2. ____
3. ____
4. ____
5. ____

Other Current Medical Diagnoses

____

____

____

Past Surgeries and Traumatic Injuries

____

____

____

Allergies & Intolerances

____

____

____

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): ____

Medications and Supplements

Current medications, supplements and herbal medicines (include additional pages, if needed). *Example:* Garden of Life Ultimate Care Probiotic; Used for constipation; Started May 2015; 1 capsule once a day.

Medication/Supplement Name & Brand	Used for	Date Started	Dosage/Frequency

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
____
____

OTHER
____

URINARY
☐ Kidney or Bladder Disease
☐ Incontinence
☐ Frequent or painful urination
☐ Kidney stones

OTHER
____

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)? ____________________

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.