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Screening Intake Form

Welcome to Our Healing Roots, LLC! We are glad you found us. This form is intended for people being diagnosed and treated under the care of an oncologist for breast cancer. 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 your discovery call. Once we receive your form, we will contact you to set up a free 20-minute discovery call. 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 her at 417-319-3081.

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 Oncologist(s) & Surgeon(s): _____
_____
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?_

_____

_____

Do you want to receive e-mails about how our business works, news, upcoming events & specials? ☐ 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 a medical diagnosis from Katrina Bogdon? ☐Yes ☐No
4. Do you intend to file these services with an insurance company (requiring diagnosis codes)? ☐Yes ☐No
5. 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

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

6. 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.

   _____

   _____

   _____

7. 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)

_____

_____

_____

8. 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

Breast Cancer History

1. When were you first diagnosed with breast cancer? _____
2. If you have experienced breast cancer recurrence, when was the latest recurrence discovered? _____
3. If you know the stage, please enter that here _____
4. Where was the breast cancer located in your body (i.e. left breast, lymph nodes, etc)

   _____
5. Is it estrogen-receptor or progesterone-receptor positive? _____
6. Is it HER2 positive? _____
7. Describe the treatments you have received to date. _____

   _____

   _____

   _____

8. How is the breast cancer currently being treated by your oncologist (i.e. active surveillance, Adriamycin/Cytoxan, radiation, etc.)? _____

_____

9. What are your current oncologist's plans for your future treatment to the best of your knowledge (i.e. active surveillance, radiation, etc)? _____

_____

_____

_____

10. What side effects are you currently experiencing from treatment?_____

_____

_____

_____

11. Have you been diagnosed with any cancer besides breast cancer? If so, what type of cancer(s) have you had? _____

_____

12. Do you have any specific goals in working with us? _____

_____

_____

_____

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 Changes
☐ Watery, itchy, or dry eyes
☐ Sinus problems
☐ Loss of taste
☐ Dental problems/mouth sores
☐ Hearing Loss/ringing of ears
☐ Earache
☐ Sore Throat
☐ Light-headed/dizzy

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

GASTROINTESTINAL
☐ Reflux/Ulcers
☐ Difficulty swallowing
☐ Inflammatory Bowel Disorder
☐ Hepatitis
☐ Gallbladder disease
☐ Constipation
☐ Abdominal pain
☐ Diarrhea
☐ Nausea/Vomiting
☐ Gas/Bloating

MUSCULOSKELETAL
☐ Back Pain
☐ Carpal Tunnel Syndrome
☐ Gout
☐ Osteoporosis
☐ Joint pain or stiffness

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

ENDOCRINE
☐ Chronic Fatigue
☐ Diabetes
☐ Thyroid Disorder
☐ Weight changes
☐ Hot flashes/night sweats
☐ Overly cold or hot

MENTAL/EMOTIONAL
☐ Depression
☐ Anxiety
☐ Alcoholism
☐ Grief
☐ Drug addiction
☐ Eating disorder
☐ Learning disorder

URINARY
☐ Kidney or Bladder Disease
☐ Incontinence
☐ Painful/frequent urination
☐ Kidney stones
☐ STD

REPRODUCTIVE
☐ Check here if you have male breast cancer
☐ Decreased sex drive
☐ Sexually active

For women only…
☐ Uterus removed
☐ Ovaries removed
☐ Fibrocystic breasts
☐ Fibroids/ovarian cysts
☐ Endometriosis
☐ Premenstrual syndrome
☐ Menopausal symptoms
Last Menstrual cycle date:
_____
☐ Vaginal infections
☐ STD
Type Date Diagnosed
_____
Date of last GYN exam:
_____
☐ Abnormal PAP
☐ Sexually active
# of pregnancies __
# of children __
Age of first period? __

CARDIOVASCULAR
☐ Arrhythmia/Palpitations
☐ Chest pain
☐ Heart Attack
☐ Stroke
☐ Heart disease
☐ Elevated cholesterol
☐ High blood pressure
☐ Heart murmur

IMMUNE/BLOOD
☐ Clotting disorder
☐ Neutropenia
☐ Slow wound healing
☐ Anemia
☐ High Iron Levels
☐ Low vitamin D

NERVOUS SYSTEM
☐ Poor memory
☐ Nerve damage
☐ Seizures
☐ Dementia
☐ Multiple Sclerosis
☐ Restless Legs

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

*Please describe what you do or study or are retired from:*_____

_____

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

_____

Who do you live with? _____

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

How many hours do you sleep? _____

How many times do you eat each day?_____

Are there any foods you avoid? _____

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

_____

_____

_____

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. You are also welcome to send us your pathology report and most recent labs to review. 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.