Dr. Wendy Rogers
NATUROPATHIC MEDICINE AND ACUPUNCTURE

Foundations for Health
12570 SW 69th Ave, Ste 101
Tigard, Oregon, US - 97223

New Patient Health Intake (2021.1)

Thank you for taking the time to thoughtfully complete this intake. It will assist in the thoroughness of your care. I'm looking forward to working with you!

Reason for visit today:

What are your most important health concerns?

Personal Details

First Name *

Last Name *

Date of Birth *

Gender ☐ Male ☐ Female ☐ Unknown

Blood Group

Language

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Unemployed ☐ Retired

Marital Status ☐ Single ☐ Married ☐ Others

Smoking Status ☐ Current every day smoker ☐ Current some day smoker ☐ Former Smoker ☐ Never Smoker ☐ Smoker ☐ current status unknown ☐ Unknown if ever smoked

Live with: ☐ Spouse ☐ Children ☐ Parents ☐ Friends ☐ Alone

Primary Contact Details

Caregiver First Name

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Caregiver Last Name _____

Email * _____

Home Phone _____

Mobile Phone _____

Work Phone _____

Fax _____

Primary Phone * ☐ Mobile Phone ☐ Home Phone ☐ Work Phone

Address Line1 * _____

Address Line2 _____

City * _____

Country * _____

State * _____

Zip code * _____

Postbox No _____

Emergency Contact Name _____

Emergency Contact Number _____

Extn _____

Insurance Information

I bill insurance and am in network with several major insurance carriers. Please make sure to check your benefits with your insurance company, you can use the form provided on my website, drwendyrogers.com.

Will we be billing insurance for your visit? * ☐ Yes ☐ No

Insurance Company: _____

Who is the primary insured? _____

If you are not the primary insured, what is the birth date of the insured? (example, spouse or parent) _____

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Insurance ID number: _____

Insurance group number: _____

Please make sure to bring your insurance card with you to your visit. If a telemedicine visit, please fax or send via messaging in the patient portal.

Family History

Are you aware of any of the following conditions running in your family and/or of any immediate family members having any of the following conditions? (Please add any further information in "notes")

- ☐ Cancer
- ☐ Autoimmune disease
- ☐ Thyroid disease
- ☐ Heart attack
- ☐ High blood pressure
- ☐ High Cholesterol
- ☐ Stroke
- ☐ Diabetes
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Glaucoma
- ☐ Kidney disease
- ☐ Epilepsy
- ☐ Alzheimer's
- ☐ Mental Illness
- ☐ Addiction

Notes:

Personal History

Are you currently established with a PCP and/or receiving healthcare? ☐ Yes ☐ No

If yes, with whom?

If no, when and where did you last receive healthcare?

List any accidents, illnesses injuries, hospitalizations/surgeries or imaging (X-ray, CAT scan, MRI etc):

General/Lifestyle

Height: _____

Weight: _____

Do you exercise regularly? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No

If yes, please specify:

☐ Rarely ☐ Occasionally ☐ Daily
☐ Past

Current Medications and Supplements

Are you hypersensitive or allergic to:

Any drugs/medications?

Any foods:

Any environmental chemicals?

List all medications (from drugstore or prescription) you are taking and dosages if known:

List all supplements you are taking and dosages if known:

Nutrition

Please list what you eat during a typical day and at what time:

Breakfast:

Lunch:

Dinner:

Snacks:

Drinks:

Do you use caffeine products (soda, coffee, tea, etc)?

☐ Yes ☐ No

If yes, what and how much? _____

Spiritual Orientation

Please list your spiritual orientation or religion:

How active are these beliefs in your life? ☐ Very active ☐ Somewhat active ☐ Not very active

Health History

For the following section, please indicate symptoms which are related to your current health concerns and other symptoms you consider to be current. For example, many individuals have experienced a headache at some time in their life but you should choose that option if it's an ongoing or current problem. Please add additional information in "notes" as needed.

General/Multi-Systems

☐ Anemia ☐ Low energy ☐ Stress
☐ Weight gain ☐ Dizziness ☐ Frequent infections
☐ Sleep issues ☐ Brain fog ☐ Changes in thirst/appetite

Notes:

Endocrine

☐ Hypothyroid ☐ Hyperthyroid (Graves Disease) ☐ Hypoglycemia (low blood sugar)
☐ Excessive hunger ☐ Goiter ☐ Diabetes
☐ Excessive thirst ☐ Excessive hair loss ☐ Cold hands/feet

Notes:

Neurologic

☐ Seizures ☐ Muscle weakness ☐ Loss of memory
☐ Paralysis ☐ Numbness/tingling ☐ Loss of balance

Notes:

Ears

☐ Ringing in ears ☐ Ear aches/congestion ☐ Frequent ear infections
☐ Impaired hearing

Notes:

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Eyes

- ☐ Impaired vision (new)
- ☐ Impaired vision (corrected w/ glasses and/or contacts)
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Eye dryness
- ☐ Eye pain
- ☐ Spots in vision
- ☐ Color blindness
- ☐ Excessive tearing

Notes:

Head/Neck

- ☐ Headaches
- ☐ Migraines
- ☐ Migraines with auras
- ☐ Neck pain
- ☐ Head injury
- ☐ Concussion
- ☐ Lumps in neck
- ☐ Swollen glands in neck
- ☐ Neck stiffness/decreased mobility

Notes:

Ears-Nose

- ☐ Ringing in ears
- ☐ Impaired hearing
- ☐ Ear infections
- ☐ Ear aches
- ☐ Nose bleeds
- ☐ Sinus congestion
- ☐ Sinus infections
- ☐ Post nasal drip
- ☐ Loss of smell
- ☐ Stuffy nose
- ☐ Seasonal allergies
- ☐ Nasal polyps

Notes:

Mouth-Throat

- ☐ Teeth grinding
- ☐ Gum problems
- ☐ Jaw pain/TMJ
- ☐ Frequent sore throat
- ☐ Hoarseness
- ☐ Difficulty swallowing
- ☐ Sore tongue or lips
- ☐ Dry mouth
- ☐ Bad breath

Notes:

Skin

- ☐ Eczema
- ☐ Hives
- ☐ Dryness of skin or scalp
- ☐ Itching
- ☐ Rashes
- ☐ Acne
- ☐ Lumps or bumps
- ☐ Suspicious mole
- ☐ Nail changes
- ☐ Easy bruising
- ☐ Color changes

Notes:

Cardiovascular

- ☐ High blood pressure
- ☐ Chest pain
- ☐ Palpitations
- ☐ Heart murmur
- ☐ Irregular heart beat/arrhythmia
- ☐ History of blood clot(s)
- ☐ History of stroke
- ☐ History of heart attack
- ☐ Low blood pressure
- ☐ Swelling in one leg/ankle
- ☐ Swelling in both legs/ankles

Notes:

Respiratory

- ☐ Shortness of breath
- ☐ Pain with breathing
- ☐ Asthma
- ☐ Cough (dry)
- ☐ Cough (productive)
- ☐ Cough (with blood)
- ☐ History of bronchitis
- ☐ History of pneumonia
- ☐ Symptoms worse lying down
- ☐ COPD

Notes:

Musculoskeletal

- ☐ Recent injury
- ☐ Muscles spasms/cramps
- ☐ Pain in neck
- ☐ Pain in upper/mid-back
- ☐ Pain in low back
- ☐ Pain in shoulder
- ☐ Change in range of motion
- ☐ Pain in arm including elbow/wrist
- ☐ Sciatica
- ☐ Pain in hips
- ☐ Pain in feet
- ☐ Pain in knees
- ☐ Pain in hands/fingers
- ☐ Pain in ankles

Notes:

Gastrointestinal

- ☐ Indigestion post-meals
- ☐ Heartburn
- ☐ Nausea
- ☐ Abdominal pain
- ☐ Excessive gas and/or bloating
- ☐ Vomiting
- ☐ Ulcer
- ☐ Constipation
- ☐ Loose stool/diarrhea
- ☐ Blood in stool (or black stools)
- ☐ Liver disease
- ☐ Gallbladder disease or removal
- ☐ Hemorrhoids
- ☐ History of pancreatitis

Notes:

Mental/Emotional

- ☐ Depression
- ☐ Anxiety
- ☐ Easily stressed
- ☐ Seasonal depression
- ☐ Poor concentration
- ☐ Memory problems
- ☐ Mood swings
- ☐ Considered suicide
- ☐ Attempted suicide
- ☐ History of abuse

Notes:

Urinary

- ☐ Frequent urination
- ☐ Urgent urination
- ☐ Pain with urination
- ☐ Inability to hold urine
- ☐ Incomplete emptying of bladder
- ☐ Frequent infections
- ☐ Dribbling
- ☐ Difficulty initiating urination
- ☐ Kidney stones (current or past)

Notes:

Women's Health

Age of first menses? _____

Age of last menses? (if menopausal) _____

Length of cycle (in days) _____

Duration of menses (in days) _____

Birth control? Type? _____

Number of pregnancies? _____

Number of live births? _____

Number of miscarriages? _____

Number of abortions? _____

Please choose all symptoms that you may be experiencing.

- ☐ Irregular cycle lengths
- ☐ Bleeding between cycles
- ☐ Heavy bleeding
- ☐ PMS (breast tenderness/mood changes)
- ☐ Endometriosis
- ☐ Pain/cramping with menses
- ☐ Pain between menses
- ☐ Hot flashes/night sweats
- ☐ Abnormal pap(s)
- ☐ Ovarian cysts
- ☐ Infertility

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Sexual Health

Sexual activity with:

☐ Males ☐ Females ☐ Both ☐ None

Please indicate any concerns or symptoms you are experiencing regardless of gender/anatomy.

☐ Low libido ☐ Pain with sexual activity ☐ Genital sores/lesions
☐ Pelvic pain ☐ Genital pain ☐ Sexual difficulties
☐ Discharge ☐ History of STI's

Notes:

Preventative Care

Please list the dates of your most recent preventative care screenings. Please leave blank if does not apply to you.

Last screening bloodwork? _____

Last annual physical? _____

Last Pap? Results? _____

Last mammogram? Results? _____

Last colonoscopy? Results? _____

Last DEXA (bone density) scan? Results? _____

Last prostate exam &/or PSA? Results? _____

Thank you again for taking the time to complete the intake in advance of your visit. I will look forward to meeting you soon!