DR. PATTY POWERS MD

Whole health Catalysts, P.C.

Dear Patient,

Welcome! And thank you for considering me as one of your health care providers.

New patient documents: Enclosed is a questionnaire I am asking you to fill out and return to me (by mail, fax or in person). If you have any medical records or lab reports that pertain to the reasons I will be meeting with you, I would appreciate the opportunity to review these before our appointment. You can mail or fax them to us, or bring them by in person.

Deposit: As soon as we receive this, we will schedule you for a consultation with me. My staff will bill your credit card for a $300.00 deposit, which will be applied to your bill for your first appointment. If you do not have a credit card, then please mail us a check for $300, payable to Patricia Powers. Upon receipt of the check, we will contact you to schedule. If you need to reschedule an appointment, a minimum of 24 hours is required.

If you do not reschedule or cancel your appointment at least 24 hours in advance, then the $300 deposit will not be refunded, and will be considered a “no show” fee.

When we meet: I will review your history, do a physical exam, and make recommendations for lab tests that will be appropriate for your specific health issues. Lifestyle and diet changes are key components to your health, and we will arrange for you to have some one-on-one help and guidance with making these changes.

After you have completed your lab tests, I will schedule an appointment with you to review your results and explain what they mean. I will create an individualized therapeutic program for you, which includes medication if needed, diet changes, nutritional supplements, and exercise, lifestyle and stress management advice.

Subsequent consults are scheduled to monitor your progress.

Payment will be due at the end of the appointment, by cash, check or credit card.

Contact us: I invite you to contact us by email via our secure Patient Portal, or by phone should you have any questions during the course of your treatment. To access the Portal, at your first visit, ask one of our staff to email you an invitation to sign up.

I use my Face Book page https://www.facebook.com/pages/Patty-Powers-MD/457560211067399 to announce educational events, workshops and group programs. I encourage you to Like my page and stay informed.

Website: www.drpattypowers.com

Location: I am located in the terrace (lower) level of Medical Associates of Central Virginia. The entrance is in the back of the building. Office hours are Monday through Friday, 8AM – 5 PM. I am usually in the office on Mondays and Thursdays.

As of September 1, 2015, I established my own Professional Corporation, separate from Medical Associates of Central Virginia. Although I still maintain my office at Medical Associates, we are separate businesses.

I look forward to assisting you in achieving your current health and wellness goals, and to guiding you in maintaining wellness throughout your life.

In health,

Patty Powers, MD and our Staff

Patricia Powers, MD
Whole Health Catalysts, P.C.
2215 Landover Pl
Lynchburg, VA 24501
434-947-5220 fax 434-544-2337

Patient's Name: _____ Today's Date:_____

Date of Birth:_____ Patient's Age_____

Address:_____

City:
_____State_____Zip_____

Home Phone_____Work
Phone_____Cell_____

Email:_____
_

Sex: M F Status: Pediatric Single Married Widowed Divorced # children_____

Occupation:_____ Employer_____Yrs Employed_____

Spouse's
Name_____Occupation_____Employer_____

How did you find out about me?
_____

For Pediatric Patients only:	
Mother's Name	Father's Name

Are there any doctors that you would like to receive copies of these records?

I authorize Dr. Powers to disclose my medical records to the above named health care providers.

Signature:_____Date:_____

Name:_____ relationship to patient:_____

Best way to contact you: home phone work phone cell phone

Circle which phone(s) I may leave messages on: home phone work phone cell phone

What are your top 3 medical issues / problems?

What are you hoping I can help you achieve?

When did these problems start? What was going on around that time?

Please list current and ongoing health problems (include ADHD, asthma, recurrent ear or strep infections, etc):

Problem	Mild	Medium	Severe	Treatment	Great success	Good success	Fair success
Example: hypothyroidism		x		levothyroxine	x		

Please check the box if any of these are problems in the past:

Diabetes	hepatitis	Arthritis	Infertility	ADHD
Hypertension	Jaundice	Osteopenia	Menstrual irregularities	Depression
High cholesterol	Urinary infections	Osteoporosis	Endometriosis	Anxiety
Thyroid problems	cystitis	hypoglycemia	Fibrocystic breasts	Bipolar
Cancer	prostatitis	Vaginitis	Uterine fibroids	Lyme disease
				Parasites

Allergies: Please list all allergies (medications, foods, pollen, etc) and the reaction(s) to each:

Immunizations: Up to date Delayed If delayed, why?

For pediatric patients only		
Mother's height	Mother's weight	Age of her first period
Father's height	Father's weight	Age he started shaving

Family History: Please take some time and do some research, ask questions of family members to get as much information as possible before our appointment. Please include health problems or cause of death for those who are deceased, also.

Maternal = mom's side Paternal = dad's side

	Mother	Father	Brother(s)	Sister(s)	Maternal grandmother	Maternal grandfather	Maternal aunt(s)	Maternal uncle(s)	Paternal grandmother	Paternal grandfather	Paternal Aunts	Paternal Uncle(s)	Other
Age (if still alive)													
Age at death (if deceased)													
ADD or ADHD													
Anxiety													
Arthritis, osteoarthritis													
Arthritis, rheumatoid													
Arthritis, other or unknown													
Asthma													
Autism													
Alzheimer's													

Bipolar disease													
Breast cancer													
Colon cancer													
Lung cancer													
Other cancer(s) (list under table)													
Celiac disease													
Depression													
Diabetes, type 1													
Diabetes, type 2													
Eczema													
Food allergies/ sensitivities													
Genetic disorders (list under table)													
Gluten sensitivity													
Goiter													
Grave's disease													
Hirsutism (excessive body hair in women)													
	Mother	Father	Brother(s)	Sister(s)	Maternal grandmother	Maternal grandfather	Maternal aunt(s)	Maternal uncle(s)	Paternal grandmother	Paternal grandfather	Paternal Aunts	Paternal Uncle(s)	Other
Heart disease in male under 55 yr or female under 65 yr													
High cholesterol or triglycerides													
High blood pressure													
Infertility													

Inflammatory bowel disease (Crohns, ulcerative colitis)													
Irritable bowel syndrome													
Learning disorders													
Lupus													
Migraines													
Obesity													
Osteoporosis													
Polycystic Ovarian Syndrome													
Psoriasis													
Precocious (early) puberty													
Late puberty													
Rheumatoid arthritis													
Short adult height (woman less than 60” or man less than 66”)													
Tall adult height													
Schizophrenia													
Stroke													
Substance abuse													
Sudden Infant Death Syndrome													
Suicide													
Hashimoto’s													
Hypothyroidism													
Hyperthyroidism													
Other thyroid problems (list below)													
Other autoimmune problems (list below)													

Other family medical problems not mentioned already or needing further explanation:

Social history

For pediatric patients:
Parents: married unmarried separated divorced
If not married, who has custody? Mother Father joint other_____
Mother's job:_____Father's job_____
Who is living in household?
_____
Where does the patient spend time when not in school? At home at sitter's daycare afterschool program
What grade is child currently in?_____Typical grades:_____

Is child in any special programs? No Yes (please list)_____
After school activities_____
Does the patient have a job? No Yes (describe)_____# hr/s week_____

For all:
Any smokers in the home? No Yes
Do you smoke? No Yes amount/day_____ Vape? No Yes
Do you drink alcohol No Yes How many drinks/week?_____
Do you use recreational drugs? No Yes What kind?
_____
How often?
_____
Any religious beliefs that would affect medical care? No Yes (describe)_____

Exercise: How many minutes/day on average?_____How many days/week?
_____
What types of exercise?
_____
How many hours of screen time per day (add up time on computer, TV, video games, phones and other electronic devices)_____
How physically fit do you think you are right now? Unfit Below average Average Above average Very fit

How much sleep does the patient get on an average night?_____

Sleep problems: No Yes
(describe)_____

How often do you drink caffeinated beverages?
_____

Main sources of stress_____

How do you deal with your stress_____

Hobbies:_____

Is there any evidence of mold in your home, school, place of work? No Yes Don't know

Medications:

Current medications (attach list if necessary)

Medication	Dose	Frequency	Start date (month/ year)	Reason for use

Previous medications

Medication	Dose	Frequency	Start date	Stop Date	Reason for use

Nutritional supplements (vitamins, minerals, homeopathy, herbs, protein powders, etc) (attach list if necessary)

Supplement and Brand	Dose	Frequency	Start date (month/ year)	Reason for use

Have any of these medications or supplements ever caused unusual side effects? No Yes (describe)

Has there been prolonged or regular use of NSAID (Aleve, Advil, Motrin, aspirin)? No Yes (If so, for what?)

Has there been prolonged or regular use of Tylenol? No Yes (if so, for what?)

Has there been prolonged or regular use of Acid Blocking Drugs (Tagamet, Zantac, Prilosec, Nexium, etc) No Yes

How many times have you been on antibiotics in your life?_____ In the last 2 years?_____

For what?

Use of steroids (prednisone, nasal allergy inhalers) in the past? No Yes (if so, why?)

Use of oral contraceptives? No Yes

Do you have any dental amalgams (silver fillings/caps?) No Yes

For pediatric patients: Mother's pregnancy history (this refers to the mother of the patient)

Illnesses none
Hypertension/high blood pressure
Preeclampsia/toxemia
Gestational diabetes
Diabetes
Other

Did mother smoke during pregnancy? No Yes if yes, how much?_____

Did mother use alcohol during pregnancy? No Yes if yes, how much?

_____

Did mother use any other recreational drugs during pregnancy? No Yes if yes, how much? _____

Did mother take any medications during pregnancy? No Yes if yes, please list_____

How much weight did mother gain during pregnancy? _____pounds

Pregnancy duration_____weeks

Delivery vaginal
Induced vaginal
Forceps
Vacuum
C/section repeat
Large baby
Failure to progress
Fetal distress

Birth weight_____lb_____ounces Birth length _____inches

Newborn history: no problems
Jaundice if so, had phototherapy? Yes No
Hypoglycemia
Respiratory problems

Feeding: breast fed Yes how many months?_____ No

Formula: how many months? _____ what kind(s)_____

What age did the child start solids?_____ dairy_____wheat_____

Please circle any of the following that were problems **in the first year of life**

Colic
Reflux
Eczema
Recurrent ear infections
RSV/bronchiolitis/wheezing/asthma
Feeding problems

Other_____

Surgery History (for all)

Please list all surgeries/operations, and what year they occurred. Please include PE tubes, dental surgery.

Surgery	Year	Reason

Injuries: Please list any significant injuries, and the year. Please include broken bones, concussions, car accidents, etc.

Hospitalizations: Please list year and reason/s

Is there anything else you can think of that may help me?

General
□ Loss of appetite
□ Increased appetite
□ Fatigue
□ Fever
□ Frequent infections
□ Trouble falling asleep
□ Trouble staying asleep
□ Nightmares or night terrors
□ Sleepwalking
□ # hrs sleep/nite?_____
□ Salt cravings
□ Sugar cravings (candy, cookies)
□ Carbohydrate cravings (bread,pasta)
□ Unusual weight gain
□ Unusual weight loss
□ Picky eater
□ Anorexia
□ Binge eating
□ Bulemia
□ Can't gain weight
□ Can't lose weight
□ Frequent dieting
□ Caffeine dependency

Skin
□ acne
□ Athlete's foot
□ Birthmark(s)
□ Bumps on back of arms
□ Coarse or brittle hair
□ Dandruff
□ Dark circles under eyes
□ Dry skin
□ Eczema
□ Hair loss
□ Jock itch
□ Oily skin
□ Hives
□ Pale skin
□ Psoriasis
□ Rash
□ Strong body odor
□ Warts

Nails
□ Bitten
□ Brittle or fragile nails
□ Curved up
□ Fungus: finger nails
□ Fungus: toenails
□Pitted
□ Ragged cuticles
□ Ridges
□ Thickened
□ White spots/lines

Eyes/Ears/Mouth
□ Change in vision (other than glasses)
□ Color blindness
□ Double vision
□ Eye redness/conjunctivitis
□ Wears glasses or contacts
□ Hearing loss or problem
□ Frequent ear infections
□ Ears get red
□ Ringing in ears
□Vertigo/spinning sensation
□ Frequent nosebleeds
□ Frequent colds
□ Nasal congestion
□ Post-nasal drip
□ Seasonal allergies
□ Sinus infections
□ Bad breath
□ Bad teeth
□ Bleeding gums or periodontal disease
□ Lots of strep throat
□ Hoarseness
□ Frequent canker sores
□ Difficulty swallowing
□ Dry mouth
□ Decreased sense of smell
□ Braces or retainer
□ Lots of cavities
□ Dental problems

Neck
□ Neck mass or lump
□ Neck swelling
□ Swollen glands
□ Goiter/enlarged thyroid
□ Dark color around neck
□ Difficulty swallowing

Respiratory
□ Asthma or wheezing
□ Bad breath
□ Chronic cough
□ Difficulty breathing with exercise
□ Apnea/stopping breathing
□ Snoring
□ Frequent pneumonia/ bronchitis

Breast
□ Discharge or leaking from breast
□ Early breast development
Age when breast development started_____
□ Breast cysts or lumps, fibrocystic
□ Breast tenderness
□ Breast development in a boy

Heart
□ High blood pressure
□ Low blood pressure
□ Fainting
□ Palpitations
□ Heart murmur

Digestive
□ Abdominal pain
□ Black, tarry stool
□ Bloating
□ Bloating after meals
□ Bloody stool
□ Burping
□ Constipation
□ Cramps
□ Diarrhea
□ Alternating diarrhea & constipation
□ Excessive gas
□ Fissures
□ Full after small amounts of food
□ Heartburn/reflux
□ Hemorrhoids
□ Indigestion
□ Intolerance: Lactose
□ Intolerance: All dairy products
□ Intolerance: Wheat

□ Intolerance: Gluten (wheat/barley/rye)
□ Intolerance: corn
□ Intolerance: eggs
□ Intolerance: fatty foods
□ Intolerance: yeast
□ Intolerance/other:
□ Irritable bowel syndrome
□ Liver disease/jaundice
□ Abnormal liver tests
□ Nausea
□ Vomiting
□ Mucus in stools
□ Undigested food in stools
Stool frequency_____per day

Endocrine
□ Feels cold a lot
□ Feels hot a lot
□ Decreased sweating
□ Excessive sweating
□ Excessive thirst
□ Excessive urination
□ Hypoglycemia
□ Shaky or irritable when hungry
□ Cold hands or feet

Urinary
□ Bedwetting
□ Blood in urine
□ Frequent urination
□ Dysuria/burning urination
□ Kidney stones
□ Leaking/incontinence
□ Urinating at night
□ Urgency (have to go NOW)
□ Many urinary infections
□ Early pubic hair

For MALES
□ Undescended testicles
□ Hernia
□ Early pubic hair
□ Low sex drive
□ Impotence
□ Infertility

For FEMALES
What age did periods start?
_____
□ Ovarian cyst(s)
□ Hernia
□ Fibroids
□ Endometriosis

Premenstrual
□ Bloating
□ Breast tenderness
□ Chocolate cravings
□ Constipation
□ Diarrhea
□ Fatigue
□ Sleep problems
□ Mood swings
□ Irritability

Menstrual
□ Cramps
□ Heavy periods
□ Irregular periods
□ No periods
□ Scanty periods
□ Spotting between periods
Last period date_____
□ Vaginal discharge
□ Vaginal odor or itching
□ Frequent vaginitis

Musculoskeletal
□ Arthritis
□ Back pain
□ Joint pain
□ Joint swelling
□ Muscle cramps
□ Muscle weakness
□ Muscle aches
□ Broken bones
□ Scoliosis
□ TMJ

Nerves/Mood
□ Anxiety
□ Clumsiness
□ Depression
Difficulty with
□ concentrating
□ balance
□ thinking
□ judgment
□ speech
□ memory
□ Fainting
□ Fearfulness/phobias
□Hallucinations
□ Headaches
□ Migraines
□ Hyperactive
□ Lightheaded
□ Numbness
□ Seizures
□ Tingling
□ Tremor

Hematology
□ Easy bruising
□ Prolonged bleeding
□ Excessive bleeding

Lymph Nodes
□ Enlarged nodes
□ Tender nodes

Name:_____Date:_____

EATING PATTERNS
Please circle your answers where appropriate

How many days per week does the patient eat breakfast?_____

Please circle where the patient eats breakfast: at home at school fast food other

What are some typical breakfast meals and beverages? (please be as specific as possible)

Is there a midmorning snack? Yes No If so, what foods/drinks?

For lunch: school meals bring from home fast food other

What are some typical lunch meals and beverages?

What does the patient typically eat and drink after school or for afternoon snacks?

What are some typical dinner meals and beverages?

Evening snacks/beverages:

How many days per week does the family sit down together for dinner?_____
How many meals per week does the patient eat at fast food restaurants?_____
Is the family eligible for SNAP/food stamps? Yes No
Are you worried about being able to afford food for the family? Yes No
How much of the following beverages does the patient drink in an average DAY?
Milk_____whole 1% 2% skim flavored Juice/juice drinks_____

Soda_____regular diet Sports drinks_____

Sugar free/flavored waters etc_____ Plain water_____

Sweet tea_____Unsweet tea_____ Other_____

How many servings of fruit in an average day?_____

How many servings of vegetables in an average day?_____

Cravings for any particular or unusual foods or drinks? No Yes If so, what?