REPOWER Long Form - Female

Welcome to Repower Medical Clinic

Who referred you to our office or how did you find us?

Your First Visit

Going to the doctor can be an overwhelming experience, especially first-time visits. Let us put your concerns to rest. Our goal is to get to the "root" of the problem and at the same time make your experience informative and comfortable. We are committed to providing you with a clear explanation of every aspect of your visit and always treat you and your time with respect.

What to Expect

We treat the cause of disease, not just the symptoms. We utilize specialty diagnostic testing to determine an individualized treatment plan for you. We focus on prevention and education and utilize scientifically sound treatments from Europe and around the World. We also conduct clinical trials and you may have the opportunity to participate if appropriate.

What to Complete and Bring to your Visit

We understand that this form takes about 45 minutes of your time. It is this information which will help Dr. Worden with your health. Please answer ALL questions. If you miss one you will not be allowed to progress to the next page. Call us with any issues you may encounter. We are here to help you through this process. In order to provide the best care, we need specific information about your medications and nutraceuticals (vitamins and herbs)

- ☐ 1. Bring all bottles of products you are CURRENTLY taking. If you prefer to bring just the label (or picture) which will suffice. Make sure to include the manufacturer and the entire label including the ingredient list.
- ☐ 2. Record of all current prescription and non-prescription medications. Bring the actual bottle, label or picture of entire label
- ☐ 3. Please bring your medical records with you or arrange for them to be sent/faxed (480-588-2235) to our office prior to your appointment.
- ☐ 4. Remember to bring your recent blood work. (Within one year)
- ☐ 5. Accept and sign all authorization forms. These forms were sent to you through your patient portal and are located in the Authorized Forms Section.

Payment

Please be prepared at the time of service to pay for your office visit. We accept checks and credit/debit cards. (Visa, MasterCard, American Express, Discover)

About Insurance

Payment is due at time of service. However, office visits and certain laboratory tests may be eligible for insurance reimbursement. Coverage varies depending on your insurance plan.

Many patients have no problem receiving partial, if not total reimbursement. We will ensure you have all the correct codes and documents to facilitate your application for reimbursement

Health History Summary

Your Current Health Problems

What is your Main Reason for coming in?

If you have a specific health condition please describe it in detail.

How long has your main problem been troubling you?

Is your current "main problem" getting (better / worse / unchanging) and for how long?

Please describe carefully any factors that you suspect may have played a role in its onset and its continuation?

List in order of importance other health problems that are troubling you

1

Length of time

2

Length of time

3

Length of time

4

Length of time

Have you ever seen a naturopathic physician, chiropractor, acupuncturist, or other alternative health practitioner for your current problem?

☐ Yes ☐ No

Name of the last holistic physician or health practitioner seen?

What was the therapy and what were the results?

When was your last therapy completed?

Do you currently have a primary care physician?(DO/MD)

☐ Yes. If yes, whom? ☐ No

Medications- If you have more than 4 medications please list any additional in the last box.

1. Name of Medication

Dose/ When/ How Often

Why do you believe you are taking this medicine and do you feel it is helping you?

2. Name of Medication

Dose/ When/ How Often

Why do you believe you are taking this medicine and do you feel it is helping you?

3. Name of Medication

Dose/ When/ How Often

Why do you believe you are taking this medicine and do you feel it is helping you?

4. Name of Medication

Dose/ When/ How Often

Why do you believe you are taking this medicine and do you feel it is helping you?

Do you have any allergies to any drugs, herbs, foods, animals or other?

☐ Yes. Please describe ☐ No ☐ unknown

What are your current conventional treatments or therapies?

1.

2.

3.

4.

5.

What is the approximate date of your most recent blood test?

Do you have any allergies to any drugs, herbs, foods, animals or other?

☐ Yes. Please describe ☐ No ☐ unknown

What is your nationality? (Please list all backgrounds and give approximate %) Example: Northern European

Mark any childhood illnesses you had?

☐ Whooping cough ☐ Measles ☐ Smallpox
☐ Chickenpox ☐ Scarlet fever ☐ Typhoid fever
☐ Mumps ☐ Rheumatic fever ☐ Mono
☐ Polio ☐ Diphtheria ☐ Tuberculosis
☐ N/A

General Health History

The general state of your health is [excellent, good, average, fair, poor] with 10 being excellent

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

On average describe your energy level from 1-10 (10 is highest, 1 is lowest)

☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

When during the day is your energy the BEST?

When during the day is your energy the WORST?

What is your weakest organ system and why?

What is your current approximate weight (lbs)?

Weight 1 year ago?

As an adult, what has been your MAXIMUM weight (not including pregnancy)

As an adult, what has been your MINIMUM weight?

What would you consider to be your desired weight?

What is your current approximate height?

Do you have any skin issues? Please describe.

Do you have any nail issues? Please describe.

Do you have any hair concerns? Please describe.

Please list the 5 most significant, stressful events in your life, from the most RECENT to the most distant.

1.

Date/Year

2.

Date/Year

3.

Date/Year

4.

Date/Year

5.

Date/Year

Are you currently working with a professional counselor, psychologist, social worker, pastor, or other therapist?

☐ Yes. If yes, please give the name and contact information.

☐ No

Have you in the past?

☐ Yes

☐ No

Do you feel the therapy was helpful?

Hospitalizations/Surgeries- If you have more than 5 Hospitalizations/Surgeries list the additional in the last box.

Previous surgeries, including dates. If exact date is not known enter the approximate year.

1. Surgery

Date / Approximate Year

2. Surgery

Date / Approximate Year

3. Surgery

Date / Approximate Year

4. Surgery

Date / Approximate Year

5. Surgery

Date / Approximate Year

Previous hospitalizations, including dates. If exact date is not know enter the approximate year.

1. Hospitalization

Date / Approximate Year

2. Hospitalization

Date / Approximate Year

3. Hospitalization

Date / Approximate Year

4. Hospitalization

Date / Approximate Year

5. Hospitalization

Date / Approximate Year

Vitamins / Herbs- If you have more than 4 Vitamins/ Herbals please list the additional in the last box.

1. Name

Dose

When/ How often

Why do you believe you are taking this product and do you feel it is helping you?

2. Name

Dose

When/ How often

Why do you believe you are taking this product and do you feel it is helping you?

3. Name

Dose

When/ How often

Why do you believe you are taking this product and do you feel it is helping you?

4. Name

Dose

When/ How often

Why do you believe you are taking this product and do you feel it is helping you?

Social History

You currently live with?

☐ spouse ☐ partner ☐ friends ☐ children ☐ alone

What is your relationship status?

☐ married ☐ widowed ☐ single ☐ in a relationship ☐ divorced

Which of the following do you currently use?

Alcohol

☐ How much? ☐ How often? ☐ N/A

Tobacco

☐ How much? ☐ How often? ☐ N/A

Hormones

☐ How much? ☐ How often? ☐ N/A

Coffee

☐ How much? ☐ How often? ☐ N/A

Cortisone

☐ How much? ☐ How often? ☐ N/A

Laxatives

☐ How much? ☐ How often? ☐ N/A

Sedatives

☐ How much? ☐ How often? ☐ N/A

Antacids

☐ How much? ☐ How often? ☐ N/A

Recreational drugs

☐ How much? ☐ How often? ☐ N/A

Is your relationship supportive?

☐ Yes ☐ No

What is your current level of education?

Are you satisfied with this?

- ☐ Yes
- ☐ No

Family History

Please list ages, health problems whether living or deceased.

Your Mother

- ☐ Living (age)
- ☐ Health Problems
- ☐ Died (age)
- ☐ Cause of Death

Your Father

- ☐ Living (age)
- ☐ Health Problems
- ☐ Died (age)
- ☐ Cause of Death

Your Brothers

- ☐ Living (ages)
- ☐ Health Problems
- ☐ Died (ages)
- ☐ Cause of Death

Your Sisters

- ☐ Living (ages)
- ☐ Health Problems
- ☐ Died (ages)
- ☐ Cause of Death

Your Maternal Grandfather

- ☐ Living (age)
- ☐ Health Problems
- ☐ Died (age)
- ☐ Cause of Death

Your Maternal Grandmother

- ☐ Living (age)
- ☐ Health Problems
- ☐ Died (age)
- ☐ Cause of Death

Your Paternal Grandfather

- ☐ Living (age)
- ☐ Health Problems
- ☐ Died (age)
- ☐ Cause of Death

Your Paternal Grandmother

- [ ] Living (age)
- [ ] Health Problems
- [ ] Died (age)
- [ ] Cause of Death

Do you have any relatives (aunt, uncle or grandparents who have had any of the following?

- [ ] allergies
- [ ] cancer
- [ ] depression
- [ ] genetic
- [ ] ulcers
- [ ] seizures
- [ ] hypoglycemia
- [ ] Alzheimer's
- [ ] Rheumatoid arthritis (autoimmune)
- [ ] arthritis
- [ ] skin
- [ ] diabetes
- [ ] high BP
- [ ] thyroid problems
- [ ] sickle cell
- [ ] autoimmune disorders
- [ ] Dementia
- [ ] None
- [ ] asthma
- [ ] anemia
- [ ] heart attack
- [ ] stroke
- [ ] STD
- [ ] cataracts
- [ ] Glaucoma
- [ ] Osteoarthritis
- [ ] Not known

Do you have any children?

- [ ] Yes. If yes, how many?
- [ ] No

List any health problems your children have.

Have you ever had toxemia during pregnancy?

- [ ] Yes
- [ ] No

Personal Habits

What do you enjoy most in your life?

What are your main interests or hobbies?

What do you worry most about in life?

Do you exercise?

- [ ] Yes. If yes, what kind, how much and how often
- [ ] No. If no, please explain why not

Do you have a spiritual belief system?

- [ ] Yes. If yes, what?
- [ ] No

On a scale of 1-10, how would you rate the quality of your sleep? (10 being the best sleep)

- [ ] 1
- [ ] 2
- [ ] 3
- [ ] 4
- [ ] 5
- [ ] 6
- [ ] 7
- [ ] 8
- [ ] 9
- [ ] 10

How many hours do you sleep at night?

Do you have problems falling asleep?
☐ Yes ☐ No

Do you awake at night?
☐ Yes. If yes, what TIME do you usually wake? ☐ No ☐ Sometimes

If yes, please explain:
☐ When did this start?
☐ How frequently does this happen?

Do you wake feeling refreshed?
☐ Yes ☐ No ☐ Sometimes

Do you nap/rest horizontally during the day?
☐ Yes ☐ No ☐ Sometimes

Length of nap time and time of day:

Do you ever sweat at night while sleeping?
☐ Yes. If yes, please indicate when this first started ☐ No ☐ Sometimes

Do you usually feel (warmer/cooler) compared to others around you?

Are your hands/feet usually (cold/hot)?

Do you enjoy your work?
☐ Yes ☐ No ☐ Somewhat

Do you take vacations?
☐ Yes ☐ No

Are you currently in a happy, satisfying relationship with someone?
☐ Very ☐ Mostly ☐ Somewhat ☐ No

How often do you get colds, flus, sore throats, yeast infections during the year?

How many days do they last?

When you rise quickly from sitting or laying do you ever get dizzy or lightheaded?
☐ Yes ☐ No

Do you get dizzy or lightheaded?
☐ Yes. If yes, how often? ☐ No

Female Reproduction

***If post menopausal please fill in this section according to symptoms experienced before menopause**

Age of first menses

If periods have stopped, at what age did they stop?

If periods have stopped, did you go through menopause naturally ?
☐ Yes ☐ No

If you had a hysterectomy do you know the cause?

Are your cycles regular?
☐ Yes ☐ No

Number of days between the beginning of your cycles? Example: 28 days

How many days does your period last? Example: 5 days

What is your typical flow?
☐ heavy ☐ medium ☐ light

Any cramps with period?
☐ Yes ☐ No

If yes, how severe are the cramps?
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What color is the blood?
☐ light red ☐ medium red ☐ dark red

Are there any clots?
☐ Yes ☐ No

Do you have any spotting or bleeding between periods?
☐ Yes ☐ No

Premenstrual symptoms (rating 1/10 10 being the worst multiioptional)

water retention
☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

breast tenderness
☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

irritability
☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

depression
☐0 ☐1 ☐2 ☐3 ☐4 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

headaches
☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

mood swings
☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

food cravings
☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Foods do you crave? (Example: Milk Chocolate vs Dark Chocolate)

Number of pregnancies

Number of abortions

Number of live births

Number of miscarriages

Do you know the cause ?

Any problems getting pregnant?
☐Yes. If yes, do you know the cause? ☐No

Do you get yearly PAP smears?
☐Yes ☐No

Any abnormal PAPs?
☐Yes ☐No

Are you HPV positive?

☐ Yes. If yes, do you know the strains of HPV? (you can ask your physician who ran the test) ☐ No

Breast lumps?

☐ Yes ☐ No

Have you had a breast biopsy?

What was the result?

When was your last mammogram

If abnormal, do you know the results?

Are you currently sexually active?

☐ Yes ☐ No

If less than one year ago what is the reason for the decrease?

Do you experience vaginal dryness?

☐ Yes. If yes, how long have you had vaginal dryness? ☐ No

Do you leak urine when you cough, sneeze or laugh?

☐ Yes. If yes, how long have you been incontenant? ☐ No

Do you experience painful intercourse?

☐ Yes. If yes, how long has this been occuring? ☐ No

Do you use birth control?

☐ Yes. If yes, list medication name and dosage. ☐ No

Were you ever (physically / sexually / emotionally / verbally) abused?

☐ Yes ☐ No

Kidneys and Bladder

Have you had recurrent bladder infections?

☐ Yes ☐ No

How were they treated?

How many bladder infections have you had in the past 3 years?

Do you have any burning sensations during or after urination?
☐ Yes ☐ No ☐ Past ☐ Present

Is your urine:
☐ dark yellow ☐ bright yellow ☐ cloudy ☐ pale ☐ clear

Does your urine have a strong odor to it?
☐ Yes ☐ No

Do you have difficulty starting or stopping when urinating?
☐ Yes ☐ No

Occupational/Household

Are you senstivie to chemical smells ? (ex. Candels, perfumes, cleaning supplies, etc)
☐ Yes, please list ☐ No

Have you been exposed at any time in your life to anything that might be environmentally harmful that you are aware of?
☐ Yes ☐ No

What was the exposure and when was it?

Have you had heavy metal or environmental exposure testing done?
☐ Yes ☐ No

If yes, was it blood, urine, hair, or stool analysis?

How long have you lived at your present address?

What state did you previously live in?

Please describe current location, if old or new place, ie: new construction, damp or moldy, near power lines or industrial buildings, etc.

New carpet or flooring?
☐ Yes ☐ No

Recent painting or remodeling?

☐ Yes ☐ No

New furniture?
☐ Yes ☐ No

Do you have specialized air filtration at home?
☐ Yes ☐ No

Last time air filters were changed?

Do you live in the city?
☐ Yes ☐ No

Do you live next to a golf course?
☐ Yes ☐ No

Do you live next to any orchards or farms?
☐ Yes ☐ No

Do you work in an office building?
☐ Yes ☐ No

Do the windows open?
☐ Yes ☐ No

Do you have specialized air filtration at work your work place?
☐ Yes ☐ No

Do you work in the presence of toxic fumes or chemicals?
☐ Yes ☐ No

Do any of your hobbies involve toxic materials? Ie: painting, building models, working with metals, yard care, working on cars, etc.
☐ Yes ☐ No

Please describe

Are you exposed to second hand smoke currently?
☐ Yes ☐ No

Were you in the past?
☐ Yes ☐ No

What do you use for your drinking water?

☐ bottled ☐ filtered. If filtered what type of system? example: reverse osmosis, charcoal, etc. ☐ tap

Do you have difficulty perspiring?
☐ Yes ☐ No

Do you have unusual perspiration?
☐ Yes. If yes, when? ☐ No

Does your perspiration have a strong smell?
☐ Yes ☐ No

Do you perspire when you exercise?
☐ light ☐ moderate ☐ heavy

As far as environmental exposures, do you have anything else you would like to comment on?

Digestions and Elimination

Do you have any problems with gas, bloating or fullness after eating?
☐ Yes ☐ No. No means never.

How Often?
☐ Often ☐ Sometimes ☐ Never

How severe is the problem? (10 being the worst)
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Where do you experience your gas?
☐ Upper abdomen ☐ Lower abdomen ☐ Both ☐ Neither

How long have you had this problem?

Number of bowel movements per day?

If less than one per day, what is the typical length of time between bowel movements?

Do you ever notice any of the following in your stools?
☐ Blood
☐ Mucus
☐ Undigested food
☐ Black color
☐ N/A

Any rectal itching?
- [ ] Yes
- [ ] No

Do you have any known External hemorrhoids?
- [ ] Yes
- [ ] No

Do you have any known Internal hemorrhoids?
- [ ] Yes
- [ ] No
- [ ] Unknown

Do your stools tend to be formed?
- [ ] Yes
- [ ] No
- [ ] Sometimes

Do your stools tend to be formed into a log?
- [ ] Yes
- [ ] No
- [ ] Sometimes

Do you stools tend to be loose?
- [ ] Yes
- [ ] No
- [ ] Sometimes

****Please answer the questions below based on the following: A normal bowel movement occurs 2-3 times a day, should be medium brown in color, should be as wide as a half dollar, and should be the length of the area from your wrist to forearm.**

In different from the description please describe your usual bowel movement. Example: shorter, thinner, etc.

How often do you have diarrhea?

Do you ever have alternating constipation and diarrhea?
- [ ] Yes
- [ ] No

How often do you have thin, long and narrow stools?
- [ ] often
- [ ] sometimes
- [ ] never

How often do you have small and hard stools?
- [ ] often
- [ ] sometimes
- [ ] never

Do you ever have yellow or light colored stools?
- [ ] often
- [ ] sometimes
- [ ] never

How often do your stools have a strong disagreeable odor?
- [ ] often
- [ ] sometimes
- [ ] never

Have you ever fasted?
- [ ] Yes
- [ ] No

For how long have you fasted?

How did you feel while you were fasting?

Have you traveled outside th US in the past 5 years?

- ☐ Yes. If yes, where?
- ☐ No

Did you get sick during or after your trip?

What were your symptoms?

Have you gone camping in the last 5 years?

- ☐ Yes. If yes, where?
- ☐ No

Did you get sick during or after your camping trip?

**** WE WOULD NOT WANT YOU TO MISS ANY SCHEDULED APPOINTMENT TIME WITH YOUR PHYSICIAN OR HAVE TO BE RESCHEDULED DUE TO MISSING INFORMATION.**

****PLEASE REVIEW THE CHECKLIST BELOW BEFORE YOUR FIRST VISIT.**

Please remember to bring and complete:

- ☐ All bottles of products you are CURRENTLY taking. If you prefer you may bring just the label (or picture) which will suffice. Make sure to include the manufacturer and the entire label including the entire ingredient list.
- ☐ Record of all current prescription and non-prescription medications. Bring the actual bottle, label or picture of entire label
- ☐ Your medical records with you or arrange for them to be sent/faxed (480-588-2235) to our office prior to your appointment.
- ☐ Remember to bring your most recent blood work. (Within one year)
- ☐ Accept and sign all authorization forms. These forms were sent to you through your patient portal and are located in the Authorized Forms Section.

Thank you for completing the intake form. We know it took some time but hope it allowed to you review your entire health picture in detail.
Dr. Worden takes the time needed to review this information with you to determine your best testing and treatments. We look forward to working with you!