

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

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?

- | | | |
|---|---|---|
| <input type="checkbox"/> allergies | <input type="checkbox"/> arthritis | <input type="checkbox"/> asthma |
| <input type="checkbox"/> cancer | <input type="checkbox"/> skin | <input type="checkbox"/> anemia |
| <input type="checkbox"/> depression | <input type="checkbox"/> diabetes | <input type="checkbox"/> heart attack |
| <input type="checkbox"/> genetic | <input type="checkbox"/> high BP | <input type="checkbox"/> stroke |
| <input type="checkbox"/> ulcers | <input type="checkbox"/> thyroid problems | <input type="checkbox"/> STD |
| <input type="checkbox"/> seizures | <input type="checkbox"/> sickle cell | <input type="checkbox"/> cataracts |
| <input type="checkbox"/> hypoglycemia | <input type="checkbox"/> autoimmune disorders | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Dementia | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Rheumatoid arthritis (autoimmune) | <input type="checkbox"/> None | <input type="checkbox"/> Not known |

Do you have any children?

- Yes. If yes, how many? No

List any health problems your children have.

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

Male Reproduction

Any prostate problems?

Yes

No

Past

Present

Last prostate exam?

PSA number if known:

How often do you have to get up at night to urinate? example: Two times

Is this more than a few years ago?

Yes

No

Any problems with impotency? (getting / maintaining an erection)

Yes

No

Any abnormal discharge from penis?

Yes

No

Any venereal (sexually transmitted) diseases?

Yes

No

Past. Please list what type

Sores on penis?

Yes

No

Past. Please list the cause

Do you experience any leakage of urine?

Yes

No

Do you have a weak urine stream?

Yes

No

Do you have trouble starting urination?

Yes

No

Do you have trouble controlling urination (dribbling)

Yes

No

Decreased libido?

Yes

No

Are you currently sexually active?

Yes. If yes, how often?

No

Is this (more/less) than 1 year ago?

More

Less

If less, do you know why?

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

Yes

No

How old and how often?

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 sensitive to chemical smells? (ex. Candles, 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 your 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.**

If 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!