



Whole Health Catalysts, P.C.

Dear Patient,

Welcome! And thank you for considering me as one of your health care providers. Jenny Hall, my assistant, and I, will do our best to assist you.

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 from the last 2 years or so, or 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, upload them to the Practice Better platform I use for email and scheduling, or bring them by in person.**

When we meet: Please bring your supplements with you. 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, but intervals vary.

Video and phone visits are available, and you can choose those options in the Practice Better patient portal. I always prefer in-person visits, but if you live a distance away, I can see you in person at least once a year, and meet virtually in-between.

Payment will be due at the end of the appointment, by cash, check, HSA, or credit card. If paying by card, there will be a 3% fee added.

Contact us: I will invite you to join our secure Patient Portal on Practice Better. This portal will allow you to schedule appointments online and email Jenny and me. You may also call, should you have any questions during the course of your treatment.

Emails: I use the Practice better portal for password-protected, HIPAA compliant emails. Please allow 1- 2 days for responses. You are welcome to ask questions via email, but if your questions are complex, I'll ask you to schedule an appointment to discuss issues in detail.

I use my Face Book page <https://www.facebook.com/pages/Patty-Powers-MD/457560211067399> and my website email newsletters to announce educational events, workshops and group programs. I encourage you to like my page and stay informed, and sign up for my newsletters on my website.

Website: www.drpatciapowers.com

Lab results: For LabCorp tests, you can set up a patient account with LabCorp or Quest to view results. You will also be able to see your results thru the patient portal on Praxis, my electronic medical record (you can set up an account for that, too). I will either give you copies of your results when we meet, or email them to you through the Practice Better program.

Location: I am located in the Virginia Vein and Wellness practice. Jenny and I are usually in the office on Mondays and Thursdays.

Please note: I am not part of the Virginia Vein and Wellness practice, so please call my number to reach me, not theirs.

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

To health in all areas of your life,

Patty Powers, MD

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

Date of Birth: _____ Patient's Age _____

Address: _____

City: _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell _____

Email: _____

I do / do not (please circle your choice) permit Dr. Powers to add me to her newsletter email list. Initials _____

Sex: M F

How did you find out about me? _____

Goal/s: prescriptions for ivermectin hydroxychloroquine strategies for immune strength

Mask exemption "vaccine" exemption Other: _____

Preferred Pharmacy:

Current weight:

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

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

Medications & Supplements

Please list your current medications and supplements, including hormones & over the counter products (attach list if necessary):

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

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

Are you very sensitive to medications or supplements? No Yes

Please circle any problems you have had, or have now:

- | | | | | |
|---------------------|----------------------|----------------------------|--------------------------|----------------------|
| ADHD | Fibrocystic breasts | Food sensitivities | IBS | Parasites |
| Anemia | Gall bladder disease | GERD/reflux | Infertility | Periodontal disease |
| Anxiety | Headaches | Heart attack | Jaundice | PCO |
| Panic attacks | Heart disease | Hepatitis | Kidney disease | Prostatitis |
| Arthritis | High cholesterol | HIV/AIDS | Liver disease | Recurrent infections |
| Asthma | Hives | Hypertension | Lung disease | Seizures |
| Bipolar | Hypoglycemia | Inflammatory bowel disease | Lyme/tick disease | Thyroid problems |
| Blood disorder | | | Meningitis | Urinary infections |
| Cancer (what type?) | | | Menstrual irregularities | Uterine fibroids |
| COVID | | | Mold illness | Vaginitis |
| Depression | | | Muscle disease | Other: |
| Diabetes | | | OCD | |
| Eczema | | | Osteopenia | |
| Endometriosis | | | Osteoporosis | |
| Fibrocystic breasts | | | | |

Anything not already mentioned?

Hospitalizations/surgeries: List all times (and reasons) you have been hospitalized, operated on, or severely injured.

Date	Hospital admissions, procedures (what & why) for all illnesses, injuries	Doctor & Medical Facility

Immunizations: Up to date Delayed Avoid do you get an annual flu vaccine? Yes No

HPV vaccines: No Yes When _____

Shingles vaccines: No Yes When _____

Covid vaccine: Yes No If yes, when: _____

which brand/s? _____

Any problems from immunizations? Yes No Describe: