CHAMPLAIN CENTER FOR
NATURAL MEDICINE

Patient Registration Form

Please print in Ink

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Sex: _____ Ethnicity: _____ Nationality: _____

Mailing Address: _____City: _____

State: _____ Zip: _____ E-mail Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Please indicate which phone number is best to reach you: _____

Primary Care Physician (we can be your PCP!) _____

Emergency Contact: _____ Contact's Phone #: _____

How did you hear about us? *Friend/Family* *Medical Referral* *Newspaper Ad* *Website*

PHARMACY USED FOR PRESCRIPTIONS: _____

Responsible Party Information if someone other than the patient is financially responsible for the patient's account.

Name_____ Phone: _____ Street Address: _____

City: _____ State: _____ Zip: _____

By supplying my home phone number, mobile phone number and email address, I authorize my health care provider or a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment or any other healthcare related function. I consent to allowing detailed messages being left on my voice mail, answering system, or with another individual, if I am unavailable at the number provided by me.

Insurance Information: Please provide your insurance card(s) to the front desk for photocopying. Please note that many out-of-state policies do not cover Naturopathic care; if in doubt, please verify! Unfortunately, Medicare will not cover our services.

Payment is expected at the time of service.

This includes amounts due for co-pays, office visits, telephone consultations, deductibles, labs, procedures and natural medicines.

- **Cancellations:** Please notify the office at least 24 business hours in advance of an appointment that needs to be rescheduled or cancelled. A $40.00 fee will be charged for missed appointments without 24 hours notice.
- **Returned Checks:** There will be a charge of $40.00 for each returned check. We will no longer accept a check if one is returned.
- **Supplement Returns:** Supplements may only be returned unopened within 30 days of purchase.

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Adult Patient Profile

Last Name: _____ First Name: _____ MI: ____

Nickname: _____ Date of Birth: _____ Age: _____ Sex: _____

Present Health Concerns
Please list your health concerns in order of priority, including date of onset and severity of symptoms.

1. _____
2. _____
3. _____
4. _____
5. _____

What do you believe is causing your most important health concerns? _____

_____

What goals do you have for your visit today? _____

_____

Healthcare Practitioners: Please list your current medical practitioners with their contact information.

	Practitioner's Name	Office Name	City	Phone
Primary Care				
OB/Gyn				
Specialist				
Therapist				
Other				
Pharmacy				

Medications: Please list any prescription drugs, over-the-counter medications and supplements (vitamins, minerals, nutrients, herbs, homeopathic remedies, etc.) you are currently taking.

Medication/Supplement	Reason	Date began	Dose

Allergies: Please list and describe any severe or life-threatening allergies (medications, stings, foods, etc.):

_____

_____

_____

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Review of Systems: Please check ☑ all that apply:

General	❍ Change in taste *or* smell	❍ Mucus in stool	❍ Blood in urine	
❍ Appetite increase	❍ Teeth / Gum problems	❍ Blood in stool	❍ Kidney stones	
❍ Appetite decrease	❍ Grinding teeth	❍ Rectal problem	**Musculoskeletal**	
❍ Dietary changes	❍ Mouth sores	❍ Hemorrhoids	❍ Neck pain	
❍ Weight Gain	❍ Dry mouth	❍ Hernia	❍ Back pain	
❍ Weight Loss	❍ Sore throat	❍ Change in bowel habits	❍ Joint pain: indicate L or R	
❍ Fevers	❍ Jaw clicking *or* pain	**Female**	❍ wrist	❍ fingers
❍ Chills	**Respiratory**	**Last Mammogram:**_____	❍ elbow	❍ shoulder
❍ Night sweats	❍ Shortness of breath	Last Bone density scan:_____	❍ hip	❍ knee
❍ Feels hot	❍ Wheezing	Last Pap smear:_____	❍ ankle	❍ foot
❍ Feels cold	❍ Asthma	Last Menstrual period:_____	❍ Joint swelling	
❍ Fatigue	❍ Bloody sputum	and length:_____	❍ Joint stiffness	
❍ Weakness	❍ Cough	❍ Irregular menstrual cycle	❍ Muscle weakness	
❍ Insomnia	❍ Snoring	❍ Bleeding between periods	❍ Muscle cramps	
❍ Sleep Apnea	**Breast**	❍ Heavy periods	**Neurological**	
❍ Thyroid problems	❍ Breast mass	❍ Painful periods	❍ Dizziness	
❍ Diabetes	❍ Breast pain	❍ Absence of menstruation	❍ Poor balance	
❍ **Skin**	❍ Nipple discharge	❍ PMS	❍ Poor coordination	
❍ Acne	❍ Recent change in size	❍ Pelvic pain	❍ Tremors *or* Shaking	
❍ Rashes	❍ Nipple pain	❍ Vaginal discharge	❍ Seizures	
❍ Itching	**Cardiovascular**	❍ Vaginal itching *or* soreness	❍ Migraines	
❍ Hives	❍ High blood pressure	❍ Vaginal dryness	❍ Numbness	
❍ Eczema	❍ Low blood pressure	❍ Sores on genitals	❍ Tingling	
❍ Mole changes	❍ Heart palpitations	❍ Infertility	❍ Nerve pain	
❍ New lesions	❍ Irregular heartbeat	❍ Sexual difficulties	❍ Memory loss	
❍ Hair loss	❍ Deep leg pain on walking	❍ Pain with intercourse	❍ Changes in speech	
❍ Nail changes	❍ Chest pain	❍ Menopausal symptoms	**Mental / Emotional**	
❍ Cracked lips	❍ Swelling of extremities	**Male**	❍ Mood changes	
❍ Increased sweating	❍ Heart murmur	Last PSA test:_____	❍ Anger	
❍ Skin color changes	❍ Cold hands/ feet	Last Prostate exam:_____	❍ Irritability	
❍ **HEENT**	❍ Lightheaded	❍ Sores on genitals	❍ Sadness	
❍ Eye Pain	❍ Varicose veins	❍ Discharge	❍ Anxiety	
❍ Cataracts	**Gastrointestinal**	❍ Testicular problems	❍ Disrupted sleep	
❍ Dry eyes	**Last Colonoscopy:**_____	❍ Prostate problems	❍ Brain fog	
❍ Glaucoma	❍ Difficulty swallowing	❍ Infertility	❍ Panic attacks	
❍ Visual changes/ problem	❍ Indigestion	❍ Sexual difficulties	❍ Suicidal thoughts	
❍ Ringing in ears	❍ Belching	❍ Difficulty with Erection	**Immune / Hematology**	
❍ Earache	❍ Heartburn	**Bladder / Kidney**	❍ Frequent infections	
❍ Itchy ears	❍ Nausea	❍ Waking to urinate	❍ Allergies to food	
❍ Excessive ear wax	❍ Vomiting	❍ Loss of bladder control	❍ Allergies to environment	
❍ Hearing loss	❍ Abdominal pain/ cramping	❍ Frequent urination	❍ Enlarged lymph nodes	
❍ Nosebleeds	❍ Gas *or* Bloating	❍ Urgent urination	❍ Anemia	
❍ Nasal Congestion	❍ Constipation	❍ Difficult urination	❍ Easy bruising	
❍ Runny nose	❍ Loose stools	❍ Chronic UTI	❍ Blood clots	
❍ Sinus problem	❍ Diarrhea	❍ Painful urination	❍	

Past Medical History: Please list the date of or age at each event and describe:

Serious Illnesses and Injuries: _____

Surgeries: _____

Hospitalizations: _____

Date of last physical/annual exam: _____ Date of last blood tests: _____

Female Reproductive History: Age of first menstrual period: _____

Number of Pregnancies: _____ Deliveries: _____ Miscarriages: _____ Abortions: _____

Personal and Family Medical History:
Please check the ☑ box next to each condition that applies to you or one of your biological family members.

				Grandparents				Siblings				
	YOU	**Mom**	**Dad**	**PGM**	**PGF**	**MGM**	**MGF**					
Current Age or Age at Death												
Alcohol / Drug Abuse												
Allergies *or* Hay Fever												
Alzheimer's *or* Dementia												
Anemia												
Anxiety / Panic Attacks												
Arthritis / Joint Disease												
Asthma												
Autoimmune Disease												
Bleeding Disorder												
Cancer *(what type?)*												
Celiac Disease												
Crohns Dis / Ulcerative Colitis												
COPD / Emphysema												
Depression / Suicide attempt												
Diabetes												
Eczema												
Epilepsy *or* Seizures												
Glaucoma												
Gall Bladder Disease												
Migraines / Headaches												
Heart Attack												
Heart Disease												
High Blood Pressure												
High Cholesterol												
HIV / AIDS												
Kidney Disease												
Liver Disease / Hepatitis												
Osteoporosis												
Schizophrenia												
Stroke												
Thyroid disorder												
Other:												

Childhood Illnesses: Please check all that apply. Your health as a child was: ❍ Good ❍ Fair ❍ Poor

❍ Chicken Pox	❍ Mononucleosis (Mono)	❍ Rheumatic Fever
❍ Diphtheria	❍ Mumps	❍ Tonsillitis
❍ Ear Infections	❍ Pertussis (whooping cough)	❍ Scarlet Fever
❍ German Measles (Rubella)	❍ Pneumonia	❍ Strep Throat (recurrent)
❍ Measles	❍ Polio	

Social History

Marital status: ❍ Single ❍ Married ❍ Civil Union ❍ Divorced ❍ Widowed ❍ Significant Other

Do you have any children? ❍ *Yes* ❍ *No* Please list their age(s): _____

Household: ❍ Alone ❍ Roommate(s) ❍ Spouse/Significant other ❍ Children ❍ Grandchildren ❍ Parent

Education level: ❍High school ❍ College ❍ Professional school ❍ Other: _____

Occupation: ❍ Student ❍ Work ❍ Homemaker ❍ Unemployed ❍ Volunteer ❍ Retired ❍ Disability

School/Job(s): _____ Hours per week: _____

Memories of your childhood: ❍ Mostly happy ❍ Mostly painful ❍ Normal ❍ Don't recall

Do you find your life: ❍ Unsatisfactory ❍ Too demanding ❍ Boring ❍ Satisfactory ❍ Wonderful

Lifestyle and Personal Habits:

What are your primary sources of stress? _____

How much does stress impact your life? _____ Hours of play/relaxation per week? _____

How do you manage stress and take care of yourself? _____

Are you:

Currently sexually active? ❍Yes ❍No Partners: # ___ ❍Male ❍Female Contraception: _____

Satisfied with your sex life? ❍Yes ❍No If no, why? _____

Satisfied with your social life? ❍Yes ❍No If no, why? _____

Satisfied with your spiritual life? ❍Yes ❍No If no, why? _____

Do you:

Enjoy your job? ❍Yes ❍No If no, why? _____

Exercise regularly? ❍Yes ❍No If no, why? _____

Which activities? _____

Sleep soundly and wake rested? ❍Yes ❍No If no, why? _____

Smoke cigarettes? ❍Yes ❍No ❍Quit date _____ Total years: _____ Packs /day: _____

Drink alcohol? ❍Yes ❍No ❍Quit date _____ Type: _____ Drinks /week: _____

Use recreational drugs? ❍Yes ❍No ❍Quit date _____ Type: _____ How often: _____

Drink caffeinated beverages? ❍Yes ❍No Type? _____ Drinks /day: _____

Diet: Please describe your typical meals.

Breakfast *Time*:_____	Lunch *Time*:_____	Dinner *Time*:_____	Snacks *Times*:_____

Do you have any dietary restrictions? _____

How often do you eat out? _____ What are your food cravings? _____

Water: _____ ounces per day Other beverages: _____