



Welcome to Champlain Center for Natural Medicine.

We are a Medical Home Primary Care office. The following information is to inform you of all that is offered to you by being a patient here. Please keep this page for your records.

Mission: Champlain Center for Natural Medicine is a medical home, committed to creating an environment where your health care needs are accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally competent. We are concerned about the complete range of health care needs of our patients to ensure whole person care; including preventative care measures, chronic condition management and behavioral health related issues.

We view ourselves as care partners with you working to develop comprehensive care plans, promote self-management and community-based support of your health care need. We practice our care using evidence-based guidelines and are happy to share them with you.

All new patients are assigned to a primary provider – who will work closely with you to optimize your health. Provider assignment is based on patient choice and provider availability – every effort is made to accommodate requests.

As your medical home we will:

- Take care of your health care needs when you are sick and we will help you to stay well.
- We will plan your care and set goals for your personal needs, for now and in the future.
- Talk with you about any testing and treatments that you may need.
- Work with you and other care providers to coordinate care.
- Provide resources, education and information regarding medications, specialists, community health team resources, home care, equipment and vendors, support services for you and your family, other key local services as the needs arise.

Hours and Availability:

- Hours: Monday, Wednesday, Friday 8:00 AM to 5:00 PM
Tuesday and Thursday 8:30 AM to 7:00 PM
- We are available to you 24/7 if you need urgent clinical advice outside of normal business hours. Please call the office and the answering machine will direct you to the on-call provider. Your calls will be returned within 60 minutes unless the provider is involved in an emergency, if that is the case, they will return your call as soon as they are available.
- For patients needing clinical advice during normal business hours we are committed to returning your calls within 72 hours.
- For patients needing to be seen urgently we provide same day appointments.
- Routine physicals and non-urgent office visits are scheduled within 30 days of the request.
- Post hospitalization follow up appointments are scheduled within 7 days.

Our staff works very hard to meet your special requests so please let us know what your needs are.

www.vtnaturalmed.com

3804 Shelburne Rd, Shelburne VT, 05482 | Ph: 802.985.8250 | Fax: 802.985.3401

Please keep this page for your records
(Page left blank for double-sided copying)

**CHAMPLAIN
CENTER
FOR NATURAL
MEDICINE**



HOLISTIC
PRIMARY CARE
SINCE 1985

Patient Registration Form
Please print in Ink

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Gender: _____ Ethnicity: _____ Nationality: _____

Mailing Address: _____ City: _____

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

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

Which phone number is best to reach you? _____ Can we leave personal information on this voicemail? Yes / No

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

Emergency Contact: _____ Relationship: _____ Phone #: _____

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

PHARMACY USED FOR PRESCRIPTIONS: _____

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

Name _____ Date of Birth: _____ 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, 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 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.

www.vtnaturalmed.com

3804 Shelburne Rd, Shelburne VT, 05482 | Ph: 802.985.8250 | Fax: 802.985.3401



Adult Patient Profile

*Please note that we *do not* provide *annual preventive visits* until you establish care AND designate us as your primary care physician with your insurance*

Last Name: _____ First Name: _____ MI: _____

Nickname: _____ Date of Birth: _____ Gender: _____

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

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

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

What goals do you have for your visit today? _____

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

Date of your last Tetanus, TD, TdaP or DTaP shot? _____

Do you require any hearing, vision or communication assistance, explain? _____

Do you have an Advance Care Directive? Yes No If yes, where is it on file? _____

If no, would you like more information on creating one? Yes No

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

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

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

Medication/Supplement with Dose	Reason	Date began

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

Personal and Family Medical History: (Please list the date of or age at each event and describe)

Serious Illnesses and Injuries: _____

Surgeries: _____

Hospitalizations: _____

Female Reproductive History: Age of first menstrual period: _____ Any complications? _____

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

Your health as a child? Good Fair Poor

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

Did anyone smoke in your childhood home(s)? Yes No

Childhood Illnesses, please check all that you have had as a child:

- Chicken pox, Diphtheria, Chronic Ear Infections, Rubella, Measles, Mumps, Mono, Pertussis, Pneumonia, Polio, Rheumatic Fever, Tonsillitis, Scarlet Fever, Chronic Strep

Please check the box next to each condition that applies to **you** or one of your **biological family members**:

KEY PGM=Paternal Grandmother

MGF=Maternal Grandfather etc. →

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

Social History:

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

Marital status? _____ Do you have any children? What ages? _____

Household: Alone Roommate(s) Partner Children Parent(s) Pets Other: _____

Occupation: Student Work Homemaker Unemployed Volunteer Retired Disability

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

Lifestyle and Personal Habits:

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

What are your primary sources of stress? _____

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

Do you have a good support system in place, i.e. family or friends whom you see or talk to regularly? _____

Do you enjoy your job? Yes No: If no, why? _____

Do you 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: _____

Would you like to become pregnant in the next year? Yes No Ok either way Unsure

Are you currently sexually active? Yes No # Partners: _____ Male Female Both

Current form of contraception used? _____

Are you satisfied with your sex life? Yes No: If no, why? _____

Are you satisfied with your social life? Yes No: If no, why? _____

Are you satisfied with your spiritual life? Yes No: If no, why? _____

Diet: Do you have any dietary restrictions? _____

Water: _____ ounces per day Other beverages: _____

Please describe your typical meals; foods and times you eat:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?

Little interest in doing things? Not at all Several days More than half the days Nearly everyday

Feeling down, depressed or hopeless? Not at all Several days More than half the days Nearly everyday

Feeling nervous, anxious or on edge? Not at all Several days More than half the days Nearly everyday

Not being able to stop or control worrying? Not at all Several days More than half the days Nearly everyday

Patient Welfare Assessment Form

Name: _____ Today's Date: _____

Family & Home:

1. How many family members, including yourself, do you currently live with? ____
2. What is your current housing situation?
 - Currently rent/own a home
 - Currently staying with others, in a hotel, or living outside.
 - I decline answering this question
3. Are you worried about losing your housing?
 - Yes
 - No
 - I decline answering this question
4. Are you a newly arrived American?
 - Yes
 - No
 - I decline answering this question

Money & Resources

5. What is the highest level of school you have completed?
 - Less than high school
 - High school degree or GED
 - College
 - Grad school
 - I decline answering this question
6. What is your current work situation?
 - Unemployed
 - Part-time or temporary work
 - Full-time work
 - Otherwise unemployed but not seeking work: i.e. Student, Stay-at-home parent, unpaid primary caregiver
 - I decline answering this question
7. Please indicate your annual income for you and family members you live with if you would like help to determine if you are eligible for any state benefits.

_____/year

Social & Emotional Health

8. In the past year, have you or any family member you live with been unable to get any of the following when needed? **check all that apply**
 - Food
 - Utilities
 - Medicine
 - Any Healthcare; Medical, Dental, Mental Health, or Vision
 - Phone
 - Clean water
 - I decline answering this question
9. Has lack of transportation kept you from any medical appointments, meetings, work, or getting supplies/food?
 - Yes
 - No
 - I decline answering this question
10. How often do you see or talk to people that you care about and feel close to, such as phone calls or visiting friends and/or family, outings to centers or gatherings etc.?
 - Less than once a month
 - 1 to 3 times a month
 - 1 to 4 times weekly
 - 5 or more times weekly
 - I decline answering this question
11. On a scale of 0 to 5, 0 being not at all 5 being all of the time, how stressed do you feel on a regular basis?
circle one
0 1 2 3 4 5
12. Do you feel physically and emotionally **un-safe** where you currently live?
 - Yes
 - No
 - I decline answering this question
13. In the past year, have you been afraid of your partner or ex-partner?
 - Yes
 - No
 - I decline answering this question

Review of Systems: Please check all that **currently apply (last 3 months)** and fill in dates when appropriate

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