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.

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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: ______________________________

<u>Responsible Party Information</u> 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.

<u>Insurance Information:</u> 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.

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# Pediatric 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: ______________

## Present Health Concerns

Please list your child's 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 child's most important health concerns? ______________________________

______________________________________________

What goals do you have for your child's visit today? ______________________________

______________________________________________

**Healthcare Practitioners:** Please list your child's current medical practitioners with their contact information.

| | Practitioner's Name | Office Name | City | Phone |
|---|---|---|---|---|
| Pediatrician | | | | |
| Specialist | | | | |
| Specialist | | | | |
| Therapist | | | | |
| Other | | | | |

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

| Medication/Supplement and Dose | Reason | Date began |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

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

______________________________________________

______________________________________________

**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: ______ Date of last blood tests: ______

**Childhood Illnesses:** Your child's health is: ❍ Good ❍ Fair ❍ Poor

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

**Immunizations:** ❍ All immunizations up to date ❍ Delayed schedule ❍ Refused immunizations

Indicate which immunizations, and dates administered, have been given to your child and any adverse reactions.

❍ DTP, ❍ DTaP *or* ❍TDaP ______
❍ MMR ______
❍ Polio (❍ IPV *or* ❍ OPV) ______
❍ Hib ______
❍ Pneumococcus (PCV) ______
❍ Hep B ______
❍ Varicella ______
❍ Other ______

**Pregnancy History:** Birth Mother: # of pregnancies: ______ # of children: ______ Age at delivery: ______

Please check any factors during pregnancy. Health during pregnancy: ❍ Good ❍ Fair ❍ Poor

❍ Alcohol Consumption
❍ Bleeding
❍ High Blood Pressure
❍ Stress
❍ Nausea
❍ Recreational Drugs
❍ Smoking
❍ Medications: ______
❍ Toxemia
❍ Trauma/Injury
❍ X-Ray

Other health problems or complications during pregnancy: ______

**Birth History:**

Term: ❍ Early ____ weeks ❍ Full Term ❍ Late ____ weeks Length of labor: ______ hours

Place of Birth: ❍ Hospital ❍ Birth Center ❍ Home ❍ Other: ______

Birth Medications (if any):

Complications: ______

**Newborn:** Weight at birth: _____ lbs _____ oz Home from hospital in _____ days

❍ Jaundice
❍ Cyanosis
❍ Infection
❍ Fever
❍ Seizures
❍ Anemia

Other important conditions: ______

Feeding: ❍ Breast Fed for______ months ❍ Formula Fed for _____ months Type of formula ______

**Developmental Milestones:** Please indicate your child's age at each milestone:

Sit up _____months, Crawl _____months, Walk _____months, First Tooth _____months, First Word _____months, First Sentence _____months, Toilet Trained _____months

Additional comments about social, cognitive, or physical development: ______

______

______

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## Personal and Family Medical History:

Please check the ☑ box next to each condition that applies to <u>your child</u> or <u>his/her *biological* family members</u>.

| *PGM=Paternal Grandmother, MGF=Maternal Grandfather etc. → | | | | Grandparents* | | | | Siblings | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Current age or Age at Death (mark w/ D and age) | Child | 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

Parents: ❍ Biological ❍ Adoptive ❍ Foster ❍ Step-parent(s)

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

Mother's Occupation:________________ Full *or* Part Time Father's Occupation: ______________ Full *or* Part Time

Siblings: ❍ *Yes* ❍ *No* Please list their age(s) ________________________________________________

Household: ❍ Parent(s) ❍ Sibling(s) ❍ Grandparent(s) ❍ Pet(s) ________________________________
❍ Other ________________________________________________________________

Pre-School/Daycare/School: ______________________________ Hours per day: _________ Days per week: _________

Personality and Habits:

How does your child react to stressful events? ______________________________

What are your child's primary sources of stress? ______________________________

How much does stress impact your child's life? ______________________________

Hours of play per day? ______________________________

Favorite activities? ______________________________

Does your child:

- Exercise regularly? ❍ Yes ❍ No What kind? ______________________________
- Sleep soundly and wake rested? ❍ Yes ❍ No If no, why? ______________________________
  Sleep: _____ hours per night Naps: _____ hours per day
- Play well with others? ❍ Yes ❍ No If no, why? ______________________________
- Enjoy time alone? ❍ Yes ❍ No If no, why? ______________________________
- Have sensory sensitivities? ❍ Yes ❍ No What kind? ______________________________
- Have strong fears or phobias? ❍ Yes ❍ No What kind? ______________________________
- Have rituals/repetitive behaviors? ❍ Yes ❍ No What kind? ______________________________

Diet:

Age Solid Foods Begun: ______ months First Foods: ______________________________

Age of Introduction for Milk /Dairy: ______ months, and Wheat: _____ months

Does your child have any dietary restrictions? ______________________________

Your child's favorite foods? ______________________________

Foods your child refuses? ______________________________

How is your child's appetite? ______________________________ Thirst? ______________________________

Please describe a typical day below:

Water: ________ oz. per day Other beverages: ______________________________

Breakfast: ______________________________

Lunch: ______________________________

Dinner: ______________________________

Snacks: ______________________________

What else would you like us to know about your child?

______________________________

______________________________

______________________________

______________________________

______________________________

______________________________

______________________________

______________________________

______________________________

Pediatric Review of Systems: Please check ☑ all that **currently apply (last 3 months)**

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

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Patient Welfare Assessment Form
(parent questionnaire)

Parent 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