**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.**

3804 Shelburne Road, Shelburne, VT 05482 • Phone (802) 985-8250 • Fax (802) 985-3401

Champlain Center for
NATURAL MEDICINE
EST. 1985
*Caring for people the way nature intended.*

# 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.

# CHAMPLAIN CENTER FOR NATURAL MEDICINE

## 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 | Reason | Date began | Dose |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

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

_____

_____

_____

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**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:**

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

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