



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: _____

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: _____ 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 _____ 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, 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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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: _____ 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. _____

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

What goals do you have for your visit today? _____

Do you require any hearing, vision or communication needs? _____

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				
OB/Gyn				
Specialist				
Therapist				
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.):

Review of Systems: Please check all that apply:

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

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

Date of last Tetanus shot: _____

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 (<i>what type?</i>)												
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
 - Diphtheria
 - Ear Infections
 - German Measles (Rubella)
 - Measles
 - Mononucleosis (Mono)
 - Mumps
 - Pertussis (whooping cough)
 - Pneumonia
 - Polio
 - Rheumatic Fever
 - Tonsillitis
 - Scarlet Fever
 - Strep Throat (recurrent)

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:

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? _____

Are you:

Currently sexually active? Yes No Contraception? _____ Partners: # ____ Male Female
 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: Do you have any dietary restrictions? _____

Water: _____ ounces per day Other beverages: _____

Please describe your typical meals.

Breakfast <i>Time:</i> _____	Lunch <i>Time:</i> _____	Dinner <i>Time:</i> _____	Snacks <i>Times:</i> _____

Patient Welfare Assessment Form

Name: _____ Date of Birth: _____

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
13. Do you feel physically and emotionally un-safe where you currently live?
 - Yes
 - No
 - I decline answering this question
15. In the past year, have you been afraid of your partner or ex-partner?
 - Yes
 - No
 - I decline answering this question