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

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 you insurance

Last Name: _____ First Name: _____ MI: ____

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

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.

Medication/Supplement	Reason	Date began	Dose

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: Indicate which immunizations have been given to your child and any adverse reactions.

❍ All immunizations up to date ❍ Delayed schedule ❍ Refused immunizations

- ❍ 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: _____

Personal and Family Medical History:
Please check the ☑ box next to each condition that applies to your child or his/her *biological* family members.

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

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

Water: _____ oz. per day Other beverages: _____

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

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