CHAMPLAIN CENTER FOR
NATURAL MEDICINE

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: _____

Please indicate which phone number is best to reach you: _____

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_____ 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.

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Pediatric Patient Profile

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				
Pharmacy				

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.):

_____ **(OVER)**

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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	❍ Mononucleosis (Mono)	❍ Rheumatic Fever
❍ Diphtheria	❍ Mumps	❍ Tonsillitis
❍ Ear Infections	❍ Pertussis (whooping cough)	❍ Scarlet Fever
❍ German Measles (Rubella)	❍ Pneumonia	❍ Strep Throat (recurrent)
❍ Measles	❍ Polio	❍ 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 *or* ❍ DTaP _____	❍ Pneumococcus (PCV) _____
❍ MMR _____	❍ Hep B _____
❍ Polio (❍ IPV *or* ❍ OPV) _____	❍ Varicella _____
❍ Hib _____	❍ 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	❍ Nausea	❍ Toxemia
❍ Bleeding	❍ Recreational Drugs	❍ Trauma/Injury
❍ High Blood Pressure	❍ Smoking	❍ X-Ray
❍ Stress	❍ Medications: _____	

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	❍ Infection	❍ Seizures
❍ Cyanosis	❍ Fever	❍ 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	First Tooth _____ months	Toilet Trained _____ months
Crawl _____ months	First Word _____ months	
Walk _____ months	First Sentence _____ 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.

Key: P=Paternal; M=Maternal; GF=Grandfather; GM=Grandmother

				Grandparents				Siblings				
	Child	**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 (**what type?**)												
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												
Macular Degeneration												
Osteoporosis												
Schizophrenia												
Stroke												
Thyroid disorder												
Other:												
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?

This form has been reviewed by the doctor with the parent.

_____ _____

Signature of Parent Date Signature of Doctor Date

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