Vermont Naturopathic Clinic

Providing integrative medicine for Vermonters…naturally!

Hello and Welcome to Vermont Naturopathic Clinic,

We are dedicated to providing excellent health care that is tailored to your specific needs. In order to do so, we ask that you please fill out the accompanying paperwork. Please take the time to fill the information out thoroughly. You may even benefit from having someone help you who knows your health history. Sometimes you may not consider an aspect of your health significant although it may be so from another's perspective.

Please bring to your appointment:

- All of the enclosed paperwork. We require a completed Informed Consent prior to treatment.
- A complete list of medications and supplements including dosages. There is a form in the enclosed paperwork for this.
- Copies of any lab work, x-ray reports, MRI reports, CT scan reports, EMG reports, etc. reports pertinent to your complaint(s) regardless of time completed or generally completed in the last year for other complaints or prevention screening.
- Insurance card: If you are covered by Worker's Compensation or Personal Injury (auto insurance), bring your claim information including claim number, adjustor contact and referral/approval letter. Note that Medicare does not cover our services, but many insurance companies do. Check your policy for details.
- Dress Appropriately: If you are coming in for evaluation of a particular area of your body please bring or wear clothing that comfortably allows examination of that area. If you are coming for acupuncture and/ or manual therapy you will need to bring these each visit.

If you have further questions, please contact our office at 802-448-3388. We look forward to meeting with you and helping you reach your goals in health and wellness.

In Health,

The providers and staff of Vermont Naturopathic Clinic

PATIENT/GUARDIAN INFORMATION

Patient Name_____

Mailing Address_____Email:_____

City_____ State_____ Zip Code_____

Date of Birth_____ Sex: M / F Preferred contact #: •Home •Work • Cell

Phone: Home_____Work _____Cell:_____

Emergency Contact_____ Phone _____ Relationship_____

INSURANCE INFORMATION

Insurance Company_____Subscriber_____

Address_____Subscriber DOB_____

Patient ID#_____Subscriber ID#_____

Group #_____Patient's relationship to Subscriber:_____

Subscriber's Employer/Address/Phone: _____

Office Policies and Notice of Privacy Practices

Financial Policy: Payment for services and dispensary items are due at time of service (insurance information, cash, check, Visa, MasterCard). You are responsible for knowing the extent of your insurance coverage, cost of co-pays and all payments. Co-pays are due at time of service.

Dispensary Returns: Any unopened item may be returned for a refund within 30 days of purchase. For mail order items the return must be postmarked by 30 days from the date of purchase. Return postage is nonrefundable.

Cancelled Appointments: We require a minimum of 24 hours notice if you need to cancel or reschedule an appointment. Failure to cancel within this time period will result in a $75 late cancellation charge.

Privacy Practice: I acknowledge that Vermont Naturopathic Clinic (VNC) has provided me with a copy of its Notice of Privacy Practices (available in the office and at http://naturopathicvermont.com/blog1/visit-information/) that describes how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints I may contact VNC at 802-448-3388. I also understand that I am entitled to receive updates upon request if VNC amends or changes its Notice of Privacy Practices in a material way.

I authorize the release of any information necessary to process my claims.

_____

Signature of Patient or Guardian Date Relationship, if signed by someone other than patient.

Vermont Naturopathic Clinic, PLC
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THIS SECTION IS TO BE COMPLETED BY THE OFFICE
IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGMENT FROM PATIENT

I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

[ ] Patient declined to sign this Written Acknowledgment.

[ ] Other (specify): _____

_____ _____
Name and signature and employee Date

Mandatory Disclosure of Information and Informed Consent for Treatment by Vermont Naturopathic Clinic PLC

You are the most important person on your health care team. You are entitled to receive clear and understandable information about the options for and methods of therapy, techniques used, and duration of therapy. If you have questions about your treatment, please contact your VNC provider. You may seek a second opinion from another healthcare professional, or terminate therapy at any time.

I understand that methods of treatment may include, but are not limited to: diet and lifestyle therapies, nutritional counseling, therapeutic use of nutrients (including oral, injection or intravenous therapy), herbal/supplement based therapy, acupuncture, moxabustion, cupping, electrical stimulation, infrared, soft tissue manipulation and/or joint manipulation or prescription medications.

Naturopathic Dispensary:

- Herbal Medicine: I understand that some herbs may need to be prepared. I understand that herbal tinctures are usually prepared with alcohol and will inform the physician if I cannot use them.
- I understand that some herbal medicines may have an unpleasant smell, taste or texture, which is not a reason for returning an item.
- I also acknowledge that unanticipated or unpleasant effects associated with a treatment are not cause for returning an item and should such a reaction occur I will immediately notify my doctor at VNC.

Acupuncture: I understand that there is some minor risk attendant to acupuncture treatment including, but not limited to, light headedness, bruising of the skin (hematoma) or slight bleeding. I understand that the risk of infection is negligible as VNC uses needles that are sterile and disposable. I understand that while this document describes the common risks of treatment, other side effect and risks may occur.

I do not expect my VNC provider to be able to anticipate and explain all risks and complications of treatment, and I wish to rely on them to exercise judgment during the course of treatment, which the doctor thinks at the time is in my best interest based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content and to discuss with my VNC provider the nature, purpose, risks and benefits of treatments provided. I understand that not all of the above-named procedures may be utilized for my treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I understand that results are not guaranteed. I hereby request and consent to the treatment and use of the procedures listed above on me (or on the patient named below, for whom I am legally responsible).

_____
Patient Signature (or guardian) Date Printed Name (minor if applicable)

PATIENT HEALTH HISTORY

Child's Name: _____ Date of Birth_____ Date: _____

Parent's Name(s):_____

Referring Doctor_____ Phone Number_____

Would you like us to be your child's primary care provider? Y N

If you were not referred how did you hear about our clinic? ad:_____ friend_____ web site_____

MAIN HEALTH PROBLEMS/ REASONS FOR THIS APPOINTMENT: (rank in terms of importance to you)

1. _____
2. _____

On-going Medical Issues (list all current diagnoses, with date of onset): _____

_____

_____

Is your child experiencing any of these symptoms in relation to your main health problem? (Circle)

Constitutional symptoms: fever, extreme fatigue

Ears, Nose, Mouth, Throat: sore throat, runny nose, ear pain, tinnitus, recurrent ear infections

Eyes: visual disturbances, discharge, redness

Heart: chest pain, palpitations, dizziness, high blood pressure, high cholesterol

Lungs: cough, wheezing, shortness of breath, asthma

Digestive system: nausea, vomiting, abdominal pain, constipation, loose stool, diarrhea, mucus or blood in stools, bloating, excessive gas, reflux

Musculoskeletal: joint pain, muscle pain, muscle weakness, decreased range of joint motion

Skin: rash, changing mole/ other lesion, Eczema

Nervous system: headache, sleep complaints, vertigo, neuropathy

Mental health: depression, anxiety, little interest or pleasure in doing things

Hormonal: excessive thirst, feel hot or cold, breast mass, excessive urination or appetite, diabetes

Blood and vessels: unusual bruising or bleeding, enlarged lymph nodes,

Allergies and Immune system:: seasonal/ persistent allergies, chronic infection: _____

Circle the level of stress you child is experiencing on a scale of 1 to 10 (1 lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress:

Child's Name: _____

Height:_____ Weight:_____

Do you consider your child: ☐ Underweight ☐ Overweight ☐ Healthy weight

Over the past two weeks how often have your child been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things:	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3

Past Medical History: List prior illnesses, injury, hospitalization, and surgery	
Event	**Date**

FAMILY HISTORY:

	Mother	**Father**	**Sisters, How many:**	**Brothers How many:**	**Grand parents Mat.**	**Pat.**
Alcoholism						
Asthma						
Auto immune disease						
Cancer (**what type?**)						
COPD / Emphysema						
Dementia						
Diabetes						
Heart Disease						
Hepatitis						
High Blood Pressure						
High Cholesterol						
Liver Disease						
Rheumatoid arthritis						
Stroke						
Other:						

Child's Name: _____

BIRTH HISTORY:

List any major patterns of illness present in your child's birth mother, father, or their families:

_____

_____

Did mother receive prenatal care? Y N Prenatal vitamins? Y N

List any pre-natal medications: _____

Did mother smoke cigarettes during pregnancy? Y N Drink Alcohol? Y N

Use drugs? Y N If yes, what type? _____

List any difficulties during pregnancy (nausea, vomiting, bleeding, etc.)

_____

What type of birth?(circle one) Home Hospital C-section Other:_____

Was the pregnancy carried to term? Y N If not, how premature? _____

Were there any complications with labor or delivery? _____

_____

PREVENTIVE CARE: Primary Doctor_____

When was your child's last physical exam/well child visit? _____

Has your child had any of the following? If yes, please list where, when and the results.

☐Electroencephalogram (EEG) _____

☐Psychological Evaluation _____

☐Hearing

Test_____

☐Speech/Language tests _____

IMMUNIZATIONS (please supply dates if known)

MMR_____ H. Influenza_____ Others_____

DTaP_____ Annual Flu_____ Adverse Reactions? Y N

Chicken Pox _____ Hep B_____ If so, what? _____

Pneumococcal _____ Polio _____

SOCIAL/NUTRITIONAL HEALTH HISTORY

Parent/Guardian's Occupation:_____

Marital Status: __Single __Married __ Partnered

Who are you living with? _____Alone ____Spouse/Partner _____Children ____Roommate

Children: How many_____ Ages_____

What do your child do for exercise?

_____

How long? _____How often?_____

Does your child have any dietary restrictions? Please list:_____

_____

Does anyone in your home currently smoke tobacco? Y N

If so, how much and for how long have they been smoking?_____

Please list any medications or supplements your child is taking below.

Medications, herbs, supplements, etc., Including strength	**Strength**	**Dosage**	**Date Started**	**Prescribing Physician**

Medication Allergies •I don't have medication allergies	**Reaction**	**Severity (mild, moderate, severe)**

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