

The Center for Integrative Health and Healing

Ronald L. Stram, MD, Director

530 Main Street, Bennington, VT Tel: (802-445-3152)/Fax:802-445-3155/www.cihh.net

Client Contact Information

(office use: ) MR# \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

The following 3 questions are required by insurance companies:

If you would prefer not to answer, please indicate with "declined". Thank you.

Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Language: \_\_\_\_\_

Phone: (day) \_\_\_\_\_ (evening) \_\_\_\_\_ (cell) \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

(email may be used for communication between practitioner and patient)

Do you wish to receive newsletters from the Center? \_\_\_yes \_\_\_no

Place of Employment: \_\_\_\_\_

Address: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Emergency Contact Phone \_\_\_\_\_:

Emergency Contact Relationship: \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

Health Insurance Company \_\_\_\_\_ ID# \_\_\_\_\_

Health Insurance Phone Number \_\_\_\_\_

Referred By (check one): \_\_\_friend; \_\_\_doctor; \_\_\_print ad; \_\_\_radio ad; \_\_\_internet; \_\_\_tel book; \_\_\_walkby.

STATEMENT REGARDING CRISIS MANAGEMENT and EMERGENCY MEDICAL CARE

As a CIHH client, I understand that the Center for Integrative Health and Healing does not provide physical or mental health crisis management. I understand if I am experiencing a physical or mental health crisis, I must obtain services that are appropriate to the type of crisis I am experiencing. If I am experiencing severe acute symptoms or a feel of life-threatening illness, I will call:

- 911
- My local hospital emergency room
- My local police or fire department
- Bennington County United Counseling Service 802-442-5491 (mental or emotional distress)

FINANCIAL AGREEMENT

As a CIHH client, I understand that I am responsible for the payment of services received through CIHH. I agree to keep my account current and will pay at the time of service unless I make some other arrangement.

I will notify the office 24 hours in advance if a cancellation is necessary. I understand that failure to do so may result in a cancellation fee for which I accept responsibility.

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To provide the best possible healthcare, we the doctors need to completely understand the patient's physical, mental and emotional condition. By providing us with this information, we will be able to understand and assist you with your health needs and goals. Please print your answers to each question as completely as possible and either mark or leave blank any questions you are unsure of.

When did you last go to a doctor's office, medical clinic or hospital? \_\_\_\_\_

What was the reason? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

What are your most important health concerns? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Please list any hospitalizations and surgeries you have had:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any allergies to foods, drugs, or other allergens in your environment (cats, mold, dust)? If yes, please explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please mark any of the following that you are taking:

- |   |   |
|---|---|
| <input type="checkbox"/> Pain relievers (aspirin, Tylenol, ibuprofen) | <input type="checkbox"/> Diet Pills/Appetite suppressants |
| <input type="checkbox"/> Cortisone (cream or pills)                   | <input type="checkbox"/> Thyroid Medication               |
| <input type="checkbox"/> Sleeping pills                               | <input type="checkbox"/> Antacids (Rolaids, Tums)         |
| <input type="checkbox"/> Laxatives                                    | <input type="checkbox"/> Tranquilizers                    |
| <input type="checkbox"/> Blood pressure medication                    | <input type="checkbox"/> Heart medication                 |
| <input type="checkbox"/> Blood Thinner(coumadin, plavix, aspirin)     | <input type="checkbox"/> Antidepressants                  |

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Please list any herbal supplements that you are currently taking:

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Please mark if you or family members have experienced the following (please indicate which family member ie: self, mother, brother etc)

\_\_\_ Cancer: \_\_\_\_\_

\_\_\_ Diabetes: \_\_\_\_\_

\_\_\_ Heart Disease: \_\_\_\_\_

\_\_\_ Blood Pressure: \_\_\_\_\_

\_\_\_ Mental Illness: \_\_\_\_\_

\_\_\_ Lung Condition: \_\_\_\_\_

\_\_\_ Allergies: \_\_\_\_\_

\_\_\_ Other: \_\_\_\_\_

Please list issues you may have regarding each category or leave blank if not applicable:

Skin: \_\_\_\_\_

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Head/Neck: \_\_\_\_\_

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Respiratory: \_\_\_\_\_

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Cardiovascular: \_\_\_\_\_

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Gastrointestinal: \_\_\_\_\_

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Urinary: \_\_\_\_\_

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Female Reproductive: \_\_\_\_\_

\_\_\_\_\_

Male Reproductive: \_\_\_\_\_

\_\_\_\_\_

Musculoskeletal: \_\_\_\_\_

\_\_\_\_\_

Neurologic: \_\_\_\_\_

\_\_\_\_\_

Psychiatric: \_\_\_\_\_

\_\_\_\_\_

What are your main interests and hobbies? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you exercise?  Yes  No  
How often? \_\_\_\_\_

What types of exercise? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you eat three meals a day?  Yes  No

Awake rested?  Yes  No

Sleep well?  Yes  No

Average hrs/night of sleep? \_\_\_\_\_

Spend time outside?  Yes  No

Take vacations?  Yes  No

Television - \_\_\_\_\_hrs/day

Reading - \_\_\_\_\_hrs/day

Use tobacco?  Yes  No

Use illegal drugs?  Yes  No

Have you ever been treated

For substance abuse or any kind? (alcohol, drugs)  Yes  No

Weight \_\_\_\_\_

Weight 1yr ago \_\_\_\_\_

Maximum Weight \_\_\_\_\_

When? \_\_\_\_\_

Height \_\_\_\_\_

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What is/are your support system(s)? \_\_\_\_\_

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What is your occupation and do you enjoy it? \_\_\_\_\_

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What are the major stresses in your life? \_\_\_\_\_

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What do you do to relax/recreate/socialize/cope with stress? \_\_\_\_\_

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When are you happiest, what gives you joy? \_\_\_\_\_

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Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Thank you for your effort. Welcome to the Center, we look forward to serving you*

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Office Use Only:	Date	Result	Date	Result	Date	Result	Date	Result	Date	Result
Pap Smear										
Mammogram										
Hemocult										
Colonoscopy										
Dexascan										

**Personal Medication History**

Date Last Updated:

Name:	Birth Date:
Pharmacy – Name and phone number	Doctor(s):
Allergic to: (also describe your reaction)	

\*\*List all prescription and over-the-counter (non-prescription) medications (Example: St. John’s Wort, Vitamins). Please include prescription medications taken as needed (Example: Nitroglycerin, pain medication, inhalers, aspirin, eye drops).

Name of Medication	Dose	Time(s) taken	Reason for Medication	Date stopped

<b>Immunization Record</b> (include date given)		<b>Additional Notes:</b>
<b>Tetanus:</b>	<b>Hepatitis:</b>	
<b>Pneumonia:</b>	<b>Flu:</b>	

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CIHH Therapeutic Agreements

**STATEMENT OF COLLABORATION**

As a CIHH practitioner, I agree to use my knowledge, skill and experience to the best of my ability in the best interest of the people who I work with. I believe it is my responsibility to:

- Assess each person’s situation based on the information they provide
- Assist them to sort through their health-related challenges
- Provide information and options about treatment modalities that are available
- Support them to make conscious decisions regarding their health
- Develop, implement and support a plan of care that will promote physical, mental and spiritual health
- Evaluate the effectiveness of a plan of care
- Make referrals to community resources as appropriate

As a CIHH client, I agree to use my knowledge, skill and experience to the best of my ability in the best interest of my own physical, mental and spiritual health. I believe it is my responsibility to:

- Provide my CIHH practitioner(s) with information that is relevant to my health
- Be willing to sort through my health-related challenges
- Ask questions related to treatment options and information that is provided
- If supplements are mutually agreed as part of my treatment plan , take them only according to directions given to me and discontinue use if side effects ensue and report this to my CIHH practitioner(s)
- Work together with my CIHH practitioner(s) to develop a plan of care that incorporates goals that are meaningful to me and will promote my physical, mental and spiritual health
- Make conscious decisions to nurture intrinsic healing and promote balance in my life
- Evaluate the effectiveness of my plan of care
- Participate in all scheduled treatment sessions

**CONFIDENTIALITY STATEMENT**

As a CIHH client, I understand that what I discuss with my CIHH practitioner(s) will be treated confidentially in accordance with law and recognized professional standards. I understand that only I can give up my right to privacy by signing a release of information.

I understand that if my safety or the safety of someone else is at risk, my CIHH practitioner(s) are legally obligated to respond by sharing this information with the appropriate resources. For example:

- Licensed Social Workers, Nurses and Physicians are mandated by Vermont State Law to report any suspicion of child abuse to the Vermont State Department of Children and Families
- Inform someone close to the client if they feel the client might harm him/herself or anyone else

CIHH practitioners believe that the concept of integrative medicine works best when CIHH practitioner discuss their work in team meetings, peer review, and/or supervision. This allows each client to benefit from the combined insight, knowledge, skill and experience of CIHH practitioners and those who supervise them. I understand that discussions of this nature would not include identifying information beyond a “need to know” basis, and such discussions would have the same privilege of confidentiality as sessions with each individual practitioner.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_