

# Clara Martin Center SAME DAY ACCESS FORM

Legal Name: _____
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What name do you go by? _____	Legal Sex: _____
Social Security Number: _____	Date of Birth: _____
Primary Language: _____	

Mailing Address:		
Physical Address:		
Home phone:	Cell:	Work phone:
Email address: _____		

<b>Gender pronouns:</b>			
<input type="checkbox"/> He/him/his	<input type="checkbox"/> She/her/hers	<input type="checkbox"/> They/them/theirs	<input type="checkbox"/> Other _____

<b>Communication Preference:</b>			
<input type="checkbox"/> Home Phone	<input type="checkbox"/> Work Phone	<input type="checkbox"/> Cell Phone	<input type="checkbox"/> Text
<input type="checkbox"/> Email	<input type="checkbox"/> Regular Mail	<input type="checkbox"/> Do Not Contact	
Is it okay to say that it's Clara Martin Center calling?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is it okay to leave a message when we call?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Would you like a reminder for your appointment?		<input type="checkbox"/> Text	<input type="checkbox"/> No (decline)
		<input type="checkbox"/> Phone Call	
		<input type="checkbox"/> Email	
Would you like to be signed up for our Client Portal? This would allow you to communicate via email, see upcoming appointments, contact med team		<input type="checkbox"/> Yes – a link will be sent to your email a link to sign up (check spam)	<input type="checkbox"/> No

**\*If there is a legal custody arrangement, we will need official documentation of that arrangement.**

<b>Parent/Guardian Information (if minor or adult with guardian):</b>	
Parent/Guardian 1:	
Name:	Relationship:
Contact Information:	
Parent/Guardian 2:	
Name:	Relationship:
Contact Information:	
Additional Parent/Guardian information and Custody arrangement:	

<b>Emergency Contact</b>	
Name:	Relationship:
Contact Information:	
Name:	Relationship:
Contact Information:	

Did someone recommend/refer you to CMC, if yes who: _____		
Are you here for mental health treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you here for substance use disorder treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, explain: _____		
Are you currently getting services for mental health treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you currently getting services for substance use disorder?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, explain: _____		
What else would you like us to know about why you are here? _____		

<b>Gross Annual Family Income:</b>		
If unknown, please choose a range:		
<input type="checkbox"/> 0- \$9,999	<input type="checkbox"/> \$40,000-\$49,000	<input type="checkbox"/> \$80,000-\$89,000
<input type="checkbox"/> \$10,000-\$19,999	<input type="checkbox"/> \$50,000-\$59,000	<input type="checkbox"/> \$90,000-\$99,999
<input type="checkbox"/> \$20,000-\$29,999	<input type="checkbox"/> \$60,000-\$69,000	<input type="checkbox"/> \$100,000 or above
<input type="checkbox"/> \$30,000-\$39,999	<input type="checkbox"/> \$70,000-\$79,000	

Number of people living on family income?
Number of children under the age of 18 in the household?

<b>Are you currently pregnant?</b>		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Applicable

<b>Do you need help with any of the following?</b>				
<input type="checkbox"/> Insurance	<input type="checkbox"/> Housing	<input type="checkbox"/> Fuel/Heat	<input type="checkbox"/> Transportation	<input type="checkbox"/> Finances
<input type="checkbox"/> Employment	<input type="checkbox"/> Medical	<input type="checkbox"/> Food	<input type="checkbox"/> Clothing	<input type="checkbox"/> Childcare
<input type="checkbox"/> Language Assistance/Interpreter Services		<input type="checkbox"/> Assistive Technology	<input type="checkbox"/> Literacy	
<input type="checkbox"/> Paperwork Assistance		<input type="checkbox"/> Cultural	<input type="checkbox"/> Other	
If Other, please explain: _____				

<b>Type of Insurance:</b>				
<input type="checkbox"/> Medicaid/Green Mountain Care	<input type="checkbox"/> Medicare	<input type="checkbox"/> BC/BS	<input type="checkbox"/> Cigna	<input type="checkbox"/> MVP
<input type="checkbox"/> Tricare	<input type="checkbox"/> Martins Point	<input type="checkbox"/> CBA Blue	<input type="checkbox"/> Other	
Policy #				
Policy Holder's Name (if different from client):				

<b>Smoking Status:</b>		
<input type="checkbox"/> Never Smoked/Vaped	<input type="checkbox"/> Current everyday smoker	<input type="checkbox"/> Occasional Smoker
<input type="checkbox"/> Current Vaper	<input type="checkbox"/> Current Smokeless tobacco user	<input type="checkbox"/> Former tobacco user

<b>Advanced Directive:</b>				
Do you have an advanced directive?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> I don't know	<input type="checkbox"/> I would like help completing one
Would you like information about a Psychiatric Advanced Directive?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		



## Clara Martin Center Fee Schedule

Services	Unit Cost Per Hour (unless otherwise indicated)
Psychotherapy (includes individual, couples, family, and family w/ client not present)	\$170.00
Group Therapy	\$115.00
Case Management – includes Community Supports and Service Planning	\$128.00
Group Community Supports	\$62.00
Mental Health/Substance Use Evaluation	\$158.00
Intensive Outpatient	\$194.00 – per group
Psychiatric Evaluation – no discounts available for psychiatric services	\$176.00
Medication Check with Therapy - cost varies depending on length of appointment and no discounts available for psychiatric services	10-19 Min. \$ 90.00 20-29 Min. \$106.00 30-39 Min. \$159.00 40-54 Min. \$214.00

The Clara Martin Center is a private, not for profit agency. You may be eligible for reduced fees based on your household income and the number of people supported by that income. The cost of services may be subsidized by the Department of Mental Health or the Department of Substance Use.

Check whichever option applies to you/your family:

☐

I would like to apply for fee reduction based on my household income and family size. I agree to provide the required written verification of income to determine eligibility for changes to the fee schedule above.

☐

I agree to pay all fees for services provided according to the fee schedule above. I acknowledge that if I change my mind in the future, I can request an application for fee reduction and provide the required written verification of income to determine eligibility for changes to the fee schedule.

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I hereby authorize payment directly to CMC for any third-party benefits to which I am entitled. I also authorize the release of any information required to process such claims. I understand that my insurance company will be billed at full cost of service. I will be responsible for that portion of the cost not paid by my insurances; in no case will that amount exceed the agreed upon fee. I further acknowledge that in the case of Urine Screenings, Dominion Diagnostic Services will be utilized as a processing center and shall consequently be the biller noted for third party reimbursement purposes.

Signature of client/guardian: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of CMC staff witness: \_\_\_\_\_

Date: \_\_\_\_\_

Created: August 2024

Reviewed and revised: August 2024



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

Client ID: \_\_\_\_\_

DATE: \_\_\_\_\_

## Clara Martin Center

### Additional Demographic and Contact Information

**Race:**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> White (Includes French Canadian) | <input type="checkbox"/> Alaskan Native         | <input type="checkbox"/> American Indian    |
| <input type="checkbox"/> Asian or Pacific Islander        | <input type="checkbox"/> Black/African American | <input type="checkbox"/> Multi-Racial       |
| <input type="checkbox"/> Other                            | <input type="checkbox"/> Unknown                | <input type="checkbox"/> Declined to answer |

**Ethnic Origin:**

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Cuban                  | <input type="checkbox"/> Mexican/Mexican American | <input type="checkbox"/> Puerto Rican       | <input type="checkbox"/> Other Hispanic |
| <input type="checkbox"/> Not of Hispanic Origin | <input type="checkbox"/> Unknown                  | <input type="checkbox"/> Declined to answer |   |

**Marital Status:**

- |  |                                  |                                      |                                    |
|--|----------------------------------|--------------------------------------|------------------------------------|
| <input type="checkbox"/> Never Married | <input type="checkbox"/> Married | <input type="checkbox"/> Civil Union | <input type="checkbox"/> Separated |
| <input type="checkbox"/> Divorced      | <input type="checkbox"/> Widowed | <input type="checkbox"/> Annulled    |                                    |

**Education:**

Last Grade or Degree Completed? \_\_\_\_\_

**Employment Status:**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Full Time                    | <input type="checkbox"/> Part-Time (20-34 hours/week)     | <input type="checkbox"/> Part-Time (less than 20 hours/week)        |
| <input type="checkbox"/> Unemployed- Looking for work | <input type="checkbox"/> Unemployed- Not looking for work | <input type="checkbox"/> Retired <input type="checkbox"/> Homemaker |
| <input type="checkbox"/> Volunteer                    | <input type="checkbox"/> Preschooler/Student              | <input type="checkbox"/> Disabled <input type="checkbox"/> Other:   |

**Are you a veteran?**

- |                              |                             |  |  |
|------------------------------|-----------------------------|--|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Currently Serving | <input type="checkbox"/> Family Member Currently Serving |
|------------------------------|-----------------------------|--|--|

**Residential Arrangement:**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Own Home/Condo/Trailer       | <input type="checkbox"/> Rent                         | <input type="checkbox"/> Section 8/Subsidized Housing       |
| <input type="checkbox"/> Residential Housing          | <input type="checkbox"/> Nursing Home/Assisted Living | <input type="checkbox"/> Temporary Housing/Living Situation |
| <input type="checkbox"/> Homeless or Homeless Shelter | <input type="checkbox"/> Other                        |   |

**Living Arrangement:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Living Alone               | <input type="checkbox"/> Living with spouse and/or minor children | <input type="checkbox"/> Living with parents or other relative |
| <input type="checkbox"/> Living with Foster Parents | <input type="checkbox"/> Living with non-related persons          | <input type="checkbox"/> Living in a group home                |
| <input type="checkbox"/> Living in an institution   | <input type="checkbox"/> Other                                    |  |

**Legal Status:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Voluntary            | <input type="checkbox"/> Court/Legislatively Mandated DUI | <input type="checkbox"/> Involuntary-Civil   |
| <input type="checkbox"/> Involuntary-Criminal | <input type="checkbox"/> Other Court Mandated             | <input type="checkbox"/> Protective Services |

**SSI Eligibility:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Eligible and receiving payments           | <input type="checkbox"/> Eligible but not receiving payments | <input type="checkbox"/> Determined ineligible |
| <input type="checkbox"/> Potentially eligible but have not applied | <input type="checkbox"/> Not applicable                      | <input type="checkbox"/> Other                 |

Mother's Maiden Name: \_\_\_\_\_



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

Client ID: \_\_\_\_\_

## Clara Martin Center

### Additional Demographic and Contact Information

Did someone recommend you come in today or refer you here?		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
If so, who?		<input type="checkbox"/> DCF	<input type="checkbox"/> Doctor's Office	<input type="checkbox"/> Medication Assisted Treatment Program	<input type="checkbox"/> Reach Up
<input type="checkbox"/> Orange County Restorative Justice Center		<input type="checkbox"/> Probation & Parole		<input type="checkbox"/> Upper Valley Haven	
<input type="checkbox"/> Other _____					
Contact information: _____					

<b><u>Emergency Contacts:</u></b>	
Check here if Emergency Contact is the same as information for legal guardians: <input type="checkbox"/>	
Name:	Relationship:
Phone number(s):	
Name:	Relationship:
Phone number(s):	



Client ID: \_\_\_\_\_

Client Name: \_\_\_\_\_ DATE: \_\_\_\_\_

## AHC HRSN Screening Tool Core Questions

### Living Situation

#### 1. What is your living situation today?

- ☐ I have a steady place to live
- ☐ I have a place to live today, but **I am worried** about losing it in the future
- ☐ I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

#### 2. Think about the place you live. Do you have problems with any of the following?

CHOOSE ALL THAT APPLY

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Pests such as bugs, ants, or mice | <input type="checkbox"/> Mold                      | <input type="checkbox"/> Lead Paint or pipes                    |
| <input type="checkbox"/> Lack of heat                      | <input type="checkbox"/> Oven or stove not working | <input type="checkbox"/> Smoke detectors missing or not working |
| <input type="checkbox"/> Water Leaks                       | <input type="checkbox"/> None of the above         |   |

### Food

Some people have made the following statements about their food situation. Please answer whether the statements were **OFTEN**, **SOMETIMES**, or **NEVER** true for you and your household in the last 12 months.

#### 3. Within the past 12 months, you worried that your food would run out before you got money to buy more.

- |                                     |   |                                     |
|-------------------------------------|---|-------------------------------------|
| <input type="checkbox"/> Often true | <input type="checkbox"/> Sometimes true | <input type="checkbox"/> Never true |
|-------------------------------------|---|-------------------------------------|

#### 4. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.

- |                                     |   |                                     |
|-------------------------------------|---|-------------------------------------|
| <input type="checkbox"/> Often true | <input type="checkbox"/> Sometimes true | <input type="checkbox"/> Never true |
|-------------------------------------|---|-------------------------------------|

### Transportation

#### 5. In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?

- |                              |                             |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|------------------------------|-----------------------------|

### Utilities

#### 6. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?

- |                              |                             |   |
|------------------------------|-----------------------------|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Already shut off |
|------------------------------|-----------------------------|---|

### Safety

Because violence and abuse happens to a lot of people and affects their health we are asking the following questions.

#### 7. How often does anyone, including family and friends, physically hurt you?

- |                                    |                                     |  |   |   |
|------------------------------------|-------------------------------------|--|---|---|
| <input type="checkbox"/> Never (1) | <input type="checkbox"/> Rarely (2) | <input type="checkbox"/> Sometimes (3) | <input type="checkbox"/> Fairly often (4) | <input type="checkbox"/> Frequently (5) |
|------------------------------------|-------------------------------------|--|---|---|

#### 8. How often does anyone, including family and friends, insult or talk down to you?

- |                                    |                                     |  |   |   |
|------------------------------------|-------------------------------------|--|---|---|
| <input type="checkbox"/> Never (1) | <input type="checkbox"/> Rarely (2) | <input type="checkbox"/> Sometimes (3) | <input type="checkbox"/> Fairly often (4) | <input type="checkbox"/> Frequently (5) |
|------------------------------------|-------------------------------------|--|---|---|

**9. How often does anyone, including family and friends, threaten you with harm?**

<input type="checkbox"/> Never (1)	<input type="checkbox"/> Rarely (2)	<input type="checkbox"/> Sometimes (3)	<input type="checkbox"/> Fairly often (4)	<input type="checkbox"/> Frequently (5)
------------------------------------	-------------------------------------	--	---	---

**10. How often does anyone, including family and friends, scream or curse at you?**

<input type="checkbox"/> Never (1)	<input type="checkbox"/> Rarely (2)	<input type="checkbox"/> Sometimes (3)	<input type="checkbox"/> Fairly often (4)	<input type="checkbox"/> Frequently (5)
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**Financial Strain****11. How hard is it for you to pay for the very basics like food, housing, medical care, and heating? Would you say it is:**

<input type="checkbox"/> Very Hard	<input type="checkbox"/> Somewhat hard	<input type="checkbox"/> Not hard at all
------------------------------------	--	--

**Employment****12. Do you want help finding or keeping work or a job?**

<input type="checkbox"/> Yes, help finding work	<input type="checkbox"/> Yes, help keeping work	<input type="checkbox"/> I do not need or want help
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**Family and Community Support****13. If for any reason you need help with day-to-day activities such as bathing, preparing meals, shopping, managing finances, etc., do you get the help you need?**

<input type="checkbox"/> I don't need any help	<input type="checkbox"/> I get all the help I need
<input type="checkbox"/> I could use a little more help	<input type="checkbox"/> I need a lot more help

**14. How often do you feel lonely or isolated from those around you?**

<input type="checkbox"/> Never	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Often	<input type="checkbox"/> Always
--------------------------------	---------------------------------	------------------------------------	--------------------------------	---------------------------------

**Education****15. Do you speak a language other than English at home?**

<input type="checkbox"/> Yes	<input type="checkbox"/> No
------------------------------	-----------------------------

**16. Do you want help with school or training? For example, starting or completing job training or getting a high school diploma, GED or equivalent.**

<input type="checkbox"/> Yes	<input type="checkbox"/> No
------------------------------	-----------------------------

**Physical Activity****17. In the last 30 days, other than the activities you did for work, on average, how many days per week did you engage in moderate exercise (like walking fast, running, jogging, dancing, swimming, biking, or other similar activities)?**

<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
----------------------------	----------------------------	----------------------------	----------------------------	----------------------------	----------------------------	----------------------------	----------------------------

**18. On average, how many minutes did you usually spend exercising at this level on one of those days?**

<input type="checkbox"/> 0	<input type="checkbox"/> 10	<input type="checkbox"/> 20	<input type="checkbox"/> 30	<input type="checkbox"/> 40	<input type="checkbox"/> 50	<input type="checkbox"/> 60	<input type="checkbox"/> 90	<input type="checkbox"/> 120	<input type="checkbox"/> 150 or greater
----------------------------	-----------------------------	-----------------------------	-----------------------------	-----------------------------	-----------------------------	-----------------------------	-----------------------------	------------------------------	---

**Disabilities****25. Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions? (5 years old or older)**

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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**26. Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping? (15 years old or older)**

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Client ID \_\_\_\_\_

## Client Rights

*As a client of Clara Martin Center, you have the right to:*

1. The basic civil and legal rights accorded to all citizens.
2. Treatment, regardless of race, color, national origin, age, sex, sexual orientation, religion, gender, ancestry, place of birth, HIV status, genetic information, gender identity, pregnancy, physical, mental or emotional condition, or disability.
3. A humane psychological and physical treatment environment, freedom from emotional abuse, physical abuse, sexual abuse, punishment, fiduciary abuse, retaliation, humiliation, and neglect.
4. Ethical treatment that meets the standards of the Agency and of the discipline of the person(s) providing treatment/training.
5. Receive prompt and adequate treatment, recovery and support services appropriate for your whole person health according to commonly accepted professional standards.
6. Participate in the development of your treatment plan. Where appropriate, and with consent, family/significant others shall have the opportunity to participate in your treatment plan development. Discharge planning will be initiated at the earliest point in the treatment planning process.
7. Freedom of choice on whether you choose to use medication as part of your recovery with the following exception: after a court hearing and final commitment order. If medication is chosen as part of your treatment plan, you have the right to be informed of the intended effects/side effects, and to be free from any unnecessary or excessive medication.
8. Exercise control over your own actions, decisions, wishes and desires as any other person of comparable age except in certain situations as defined under Vermont law.
9. The least restrictive conditions necessary to achieve the purpose of treatment.
10. Be informed of your condition and progress.
11. Have your treatment record and all information about you kept confidential except where state law or court order requires disclosure. Consents and authorizations for release of information will be in accordance with Clara Martin Center policies on privacy and confidentiality.
12. The right to request access to your protected health information by alternative means or at alternative locations for the purpose of confidential communications.
13. The right to voice complaints or lodge an appeal without retaliation, and the right to the investigation and resolution of alleged infringement of rights.
14. Refuse to provide authorizations for the use and disclosure of protected health information; except if the treatment is research-related with client consent or if the health information is to be created for the purpose of disclosure to a third party.
15. The right to all legal protection and due process for status as an outpatient and inpatient, both voluntary and involuntary, as defined under Vermont law, and obtain information for legal services for appropriate representation.
16. Obtain information on self-help and advocacy support services.
17. Communication of these rights in a way that is understandable to you. Your signature (or your guardian's) will serve as acknowledgment of receipt of this information.

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Client or Parent/Guardian Signature

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Client Name

---

Date



Client ID:  
Client Name:



# Clara Martin Center

*People Helping People*

Randolph, VT  
802-728-4466

Bradford, VT  
802-222-4477

Wilder, VT  
802-295-1311

## Attendance Policy

The Clara Martin Center values providing effective and efficient services to everyone we serve. We understand that life can sometimes get in the way of scheduled appointments. If you need to reschedule your appointment, please give us at least 24-hour notice. If you cancel or reschedule with less than 24-hour notice, your appointment may be considered a “no-show.”

If you have two or more no-show appointments within 30 days or two consecutive, no-show appointments:

- You must speak with an Engagement Specialist before we schedule another appointment. The specialist will discuss barriers to attendance and the scheduling plan moving forward.
- Your future appointments may be scheduled to be less frequent.

I have reviewed and understand the no-show policy.

Client signature: \_\_\_\_\_ Date: \_\_\_\_\_

Clinician signature: \_\_\_\_\_ Date: \_\_\_\_\_

Client ID: \_\_\_\_\_

Date: \_\_\_\_\_

## Clara Martin Center Client Medical History

<b>Name:</b> _____		<b>D.O.B</b> _____
<b>Height:</b> _____ ft _____ in		<b>Weight:</b> _____ lbs.
<b>Legal Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Choose not to disclose		
<b>Gender Identity:</b> <input type="checkbox"/> Agender <input type="checkbox"/> Boy/Man <input type="checkbox"/> Girl/Woman <input type="checkbox"/> Gender Expansive <input type="checkbox"/> Genderqueer <input type="checkbox"/> Trans Man/Trans Boy <input type="checkbox"/> Trans Woman/Trans Girl <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> Other _____		<b>Personal Gender Pronouns:</b> <input type="checkbox"/> He/Him/His <input type="checkbox"/> She/Her/Hers <input type="checkbox"/> They/Them/Theirs <input type="checkbox"/> Other _____

Primary Care Physician and Dentist			
Dr.'s Name _____ Phone Number: _____			
Dentist Name _____ Phone Number: _____			
Primary Care Facility Name			
<input type="checkbox"/> Alice Peck Day	<input type="checkbox"/> Ammonoosuc Health Center	<input type="checkbox"/> Barre Internal Medicine	<input checked="" type="checkbox"/> CVMC Adult Primary Care Berlin
<input type="checkbox"/> CVMC Associates In Pediatric	<input type="checkbox"/> CVMC Family Medicine- Berlin	<input type="checkbox"/> CVMC Family Medicine- Mad River	<input type="checkbox"/> CVMC Family Medicine- Waterbury
<input type="checkbox"/> CVMC- Green Mountain Family Practice	<input type="checkbox"/> CVMC Integrative Family Medicine-Montpelier	<input type="checkbox"/> DHMC	<input type="checkbox"/> DHMC-Heater Road
<input type="checkbox"/> DHMC-Lyme	<input type="checkbox"/> Gifford Medical Center	<input type="checkbox"/> Gifford-Berlin	<input type="checkbox"/> Gifford-Bethel
<input type="checkbox"/> Gifford-Chelsea	<input type="checkbox"/> Gifford-South Royalton	<input type="checkbox"/> Hardwick Area Health Center	<input type="checkbox"/> Ideal Primary Care
<input type="checkbox"/> Little Rivers Health Care	<input type="checkbox"/> Montshire Pediatrics	<input type="checkbox"/> Mt. Ascutney Health Center	<input type="checkbox"/> Newbury Health Clinic
<input type="checkbox"/> Ottaqueeche Health Center	<input type="checkbox"/> Plainfield Health Center	<input type="checkbox"/> Rowe Health Center	<input type="checkbox"/> Upper Valley Pediatrics
<input type="checkbox"/> UVM	<input type="checkbox"/> White River Family Practice	<input type="checkbox"/> White River Junction VA	
<input type="checkbox"/> Other _____			

Client ID: \_\_\_\_\_

Pharmacy Information	
Pharmacy Name:	_____
Pharmacy Phone Number:	_____

Personal Health History	
1. Do you have any chronic health conditions (e.g., diabetes, heart disease, asthma)?	
2. Have you ever had surgery or major medical procedures?	
3. Are you currently taking any medications or supplements?	
4. Have you ever been diagnosed with mental health conditions (e.g., depression, anxiety)?	
5. Do you have any allergies (food, medication, environmental)?	
6. Have you ever been hospitalized or in intensive care?	
7. Do you have any family history of chronic diseases (e.g., heart disease, diabetes)?	
8. Have you ever had a blood transfusion?	
9. Do you have any recent or past infections (e.g., HIV, hepatitis)?	
10. Have you ever been involved in a significant injury or trauma?	
11. Do you have any current or past substance use (alcohol, tobacco, drugs)?	
12. Have you ever been diagnosed with a blood clot or other vascular condition?	
13. Do you have any autoimmune or inflammatory conditions (e.g., rheumatoid arthritis)?	
14. Have you ever had a stroke or transient ischemic attack (TIA)?	
15. Do you have any current or past cancer diagnoses?	
16. Have you ever been diagnosed with a kidney or liver condition?	
17. Do you have any current or past thyroid conditions?	
18. Have you ever been diagnosed with a bone condition (e.g., osteoporosis)?	
19. Do you have any current or past neurological conditions (e.g., multiple sclerosis)?	
20. Have you ever been diagnosed with a skin condition (e.g., eczema, psoriasis)?	
21. Do you have any current or past hearing or vision impairments?	
22. Have you ever been diagnosed with a dental or oral condition (e.g., gum disease)?	
23. Do you have any current or past reproductive health issues?	
24. Have you ever been diagnosed with a blood disorder (e.g., anemia)?	
25. Do you have any current or past endocrine conditions (e.g., hypothyroidism)?	
26. Have you ever been diagnosed with a gastrointestinal condition (e.g., Crohn's disease)?	
27. Do you have any current or past respiratory conditions (e.g., COPD)?	
28. Have you ever been diagnosed with a urinary condition (e.g., kidney stones)?	
29. Do you have any current or past infectious diseases (e.g., tuberculosis)?	
30. Have you ever been diagnosed with a neurological condition (e.g., Parkinson's disease)?	
31. Do you have any current or past autoimmune conditions (e.g., lupus)?	
32. Have you ever been diagnosed with a blood vessel condition (e.g., aneurysm)?	
33. Do you have any current or past skin conditions (e.g., melanoma)?	
34. Have you ever been diagnosed with a dental condition (e.g., periodontitis)?	
35. Do you have any current or past reproductive health issues (e.g., infertility)?	
36. Have you ever been diagnosed with a blood condition (e.g., leukemia)?	
37. Do you have any current or past endocrine conditions (e.g., hyperthyroidism)?	
38. Have you ever been diagnosed with a gastrointestinal condition (e.g., ulcer)?	
39. Do you have any current or past respiratory conditions (e.g., asthma)?	
40. Have you ever been diagnosed with a urinary condition (e.g., urinary tract infection)?	
41. Do you have any current or past infectious diseases (e.g., hepatitis)?	
42. Have you ever been diagnosed with a neurological condition (e.g., Alzheimer's disease)?	
43. Do you have any current or past autoimmune conditions (e.g., rheumatoid arthritis)?	
44. Have you ever been diagnosed with a blood vessel condition (e.g., stroke)?	
45. Do you have any current or past skin conditions (e.g., melanoma)?	
46. Have you ever been diagnosed with a dental condition (e.g., periodontitis)?	
47. Do you have any current or past reproductive health issues (e.g., infertility)?	
48. Have you ever been diagnosed with a blood condition (e.g., leukemia)?	
49. Do you have any current or past endocrine conditions (e.g., hyperthyroidism)?	
50. Have you ever been diagnosed with a gastrointestinal condition (e.g., ulcer)?	
51. Do you have any current or past respiratory conditions (e.g., asthma)?	
52. Have you ever been diagnosed with a urinary condition (e.g., urinary tract infection)?	
53. Do you have any current or past infectious diseases (e.g., hepatitis)?	
54. Have you ever been diagnosed with a neurological condition (e.g., Alzheimer's disease)?	
55. Do you have any current or past autoimmune conditions (e.g., rheumatoid arthritis)?	
56. Have you ever been diagnosed with a blood vessel condition (e.g., stroke)?	
57. Do you have any current or past skin conditions (e.g., melanoma)?	
58. Have you ever been diagnosed with a dental condition (e.g., periodontitis)?	
59. Do you have any current or past reproductive health issues (e.g., infertility)?	
60. Have you ever been diagnosed with a blood condition (e.g., leukemia)?	
61. Do you have any current or past endocrine conditions (e.g., hyperthyroidism)?	
62. Have you ever been diagnosed with a gastrointestinal condition (e.g., ulcer)?	
63. Do you have any current or past respiratory conditions (e.g., asthma)?	
64. Have you ever been diagnosed with a urinary condition (e.g., urinary tract infection)?	
65. Do you have any current or past infectious diseases (e.g., hepatitis)?	
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68. Have you ever been diagnosed with a blood vessel condition (e.g., stroke)?	
69. Do you have any current or past skin conditions (e.g., melanoma)?	
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108. Have you ever been diagnosed with a blood condition (e.g., leukemia)?	
109. Do you have any current or past endocrine conditions (e.g., hyperthyroidism)?	
110. Have you ever been diagnosed with a gastrointestinal condition (e.g., ulcer)?	
111. Do you have any current	

Date of last Physical Exam: \_\_\_\_\_

Are all immunizations up to date? ☐ Yes ☐ No

**List any medical/mental health problems that other doctors have diagnosed you with**

Have you had an ER visit in the last 6 months? ☐ Yes ☐ No

Other hospitalizations	<input type="checkbox"/> None
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Year	Reason	Hospital

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers ☐ None

[illegible]

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

Client ID: \_\_\_\_\_

<b>Allergies to medications</b>		<input type="checkbox"/> <b>None</b>
<b>Name the Drug</b>	<b>Reaction You Had</b>	

Do you have any concerns in the following areas		
Sensory (vision, hearing, sense of touch/smell, reactions to sensory stimulation, hallucinations, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Motor (coordination, gait, balance, posture, movements, tics, nervous habits or mannerisms)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Language (delays, comprehension problems, speech difficulties)	<input type="checkbox"/> Yes	<input type="checkbox"/> No

FAMILY HEALTH HISTORY				
Is there a family history (parents, grandparents, siblings) in any of the following?				
<input type="checkbox"/> Cancer	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Seizure Disorder	<input type="checkbox"/> Thyroid Disease		