Stram Center for Integrative Medicine

Client Contact Information

(office use:) MR#_____

NAME:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

DOB:_____ AGE:_____ GENDER:_____

Relationship/Marital Status: (circle one): Single / Married / Partnered / Living Together / Divorced

Home Telephone: (____) _____ - _____OK to leave message? Y / N

Work Telephone: (____) _____ - _____OK to leave message? Y / N

Cell Phone: (____) _____ - _____ OK to leave message? Y / N

E-Mail Address:_____
OK to contact via email? Y / N
Are you interested in receiving newsletters and updates? Y / N

Place of Employment:_____

Emergency Contact:_____
Emergency Contact Phone:_____
Emergency Contact Relationship:_____

Primary Care Physician:_____PCP Phone Number:_____
Pharmacy:_____Pharmacy Phone Number:_____

Health Insurance Company _____ID#_____
Health Insurance Phone Number_____

Referred By (check one):
___Friend - Referring friend:_____
___Doctor - Referring Physician:_____
___Print Ad ___Radio Ad ___Internet ___Telephone Book ___Walk-by

Financial Statement: As a Stram Center patient, I understand that I am responsible for the payment of services received. I agree to keep my account current and will pay at the time of service. I will notify the office 24 hours in advance if a cancellation is necessary, otherwise I will be responsible for a missed appointment fee or forfeiting any deposits.

Client Signature:_____**Date:**_____

Stram Center for Integrative Medicine

Name:_____**Date:**_____

Chief Complaint:_____

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:

___Pain relievers (aspirin, Tylenol, ibuprofen)
___Cortisone (cream or pills)
___Sleeping pills
___Laxatives
___Blood pressure medication
___Blood Thinner (coumidin, plavix, aspirin)
___Diet Pills/Appetite suppressants
___Thyroid Medication
___Antacids (Rolaids, Tums)
___Tranquilizers
___Heart medication
___Antidepressants

Please list any herbal supplements that you are currently taking:_____

Stram Center for Integrative Medicine

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:_____

Head/Neck:_____

Respiratory:_____

Cardiovascular:_____

Gastrointestinal:_____

Urinary:_____

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

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Weight:_____ Weight 1yr ago:_____ Maximum Weight, When?_____ Height:_____

What is/are your support system(s)?_____

What is your occupation and do you enjoy it?_____

What are the major stresses in your life?_____

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

When are you happiest, what gives you joy?_____

Client Signature:_____ **Date**:_____
OR PARENT/GUARDIAN OF MINOR CHILD

Thank you for your effort.
Welcome to the Stram Center, we look forward to helping you feel your best.

Stram Center for Integrative Medicine

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**

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

Immunization Record (include date given)		**Additional Notes:**
Tetanus:	**Hepatitis:**	
Pneumonia:	**Flu:**	

** **Keep this list with you.** **

Bring this list to your doctor visits, the hospital and all medical tests.

- ✓ Update this form when medications change.

Stram Center for Integrative Medicine

Financial Agreement

Medicare Patients

I,_____understand that Dr. Ronald Stram, MD is the only Stram Center staff enrolled in the Medicare program as a non-participating physician and therefore accept responsibility for payment of services to Dr. Ronald Stram at the time service is rendered. Furthermore, I understand that I will be charged the Vermont allowed Medicare fees and Medicare will be billed on my behalf for these fees. All eligible reimbursements for these services will be sent to me directly from Medicare.

Self-Pay Patients

I,_____understand that if the Stram Center medical staff are non-participating with my current insurance plan carrier I therefore accept responsibility for payment of services at the time service is rendered. Furthermore, I understand that my current insurance plan will not be billed on my behalf for fees paid.

If you are unable to keep your scheduled appointment, please notify us at least 24 hours in advance so that we can accommodate our other patients with a vacant appointment. You may also reschedule your appointment at that time. Failure to provide our office with 24 hour notification will incur a missed appointment fee or loss of deposit. Being more than 15 minutes late may result in the need to reschedule your appointment.

Patient Name:_____

Signature:_____

Date:_____

Stram Center for Integrative Medicine

Lab Results Office Policy

This laboratory policy is instated to preserve the relationship-oriented care in the treatment of our patients, thus maintaining quality of care and communication with all patients.

Please read the following carefully:

- It is the Stram Center's office policy that all laboratory results are discussed in person with our patients. If this is not possible, minimally, it must be done during a scheduled phone consultation.

- Please do not call the office for results of lab work and/or imaging. **Reports are not given over the phone, unless the practitioner deems that the results are critical or urgent in nature.**

- If you are getting lab work, please schedule your follow-up appointment *at the time of your visit for review of those lab results and subsequent treatment options***. A copy of your lab report will be given to you at your follow up appointment.** All lab testing should be done in a timely manner so that your results will be complete by the time of your next scheduled visit.

- If your practitioner has reviewed your lab report and deems the results do not require a follow up discussion, you will be contacted. At the time you may choose to cancel your scheduled follow up appointment, request a copy of your lab report or keep your scheduled appointment.

- We do not release copies of lab results to any party until reviewed by the Stram Center medical staff, and without written permission according to HIPAA guidelines. Please allow ample time for laboratories to report test results in full and for them to be reviewed by your medical practitioner.

I, the undersigned, understand that I may only receive copies of my lab results at my scheduled follow-up appointment or after discussing results in a scheduled phone consultation. I will comply with the office policies and procedures discussed above.

Patient Name:_____

Patient Signature:_____

Date:_____

Stram Center for Integrative Medicine

MEDICINARY DISCLAIMER

I,_____, fully understand that the statements and treatment plan regarding supplements discussed with me by the Stram Center Medical staff may not have been evaluated by the FDA. Some of the supplements recommended are to support the body's system functions. There may be adverse effects and contraindications to any one of these supplements that are recommended. These products are not intended to diagnose, treat, cure or prevent any disease.

The Stram Center Medical staff does not claim that any or all of the products suggested will stimulate, maintain, regulate or promote structure of the body or restore normal or correct abnormal function. I also understand that I am not obligated to buy any or all supplements at this location. I am free to obtain them from other sources.

Patient Name:_____

Patient Signature:_____

Date:_____

Stram Center for Integrative Medicine

Patient Guidelines for Contacting the Office

In order to best serve all our patients, please read these guidelines for contacting our office for matters concerning the following:

Questions for your Practitioner

We understand you may have questions for your practitioners. As practitioners are seeing scheduled patients during the day, there is not always ample time for them to take your calls directly. Please leave a detailed message with one of the office staff who will give your message to your practitioner; please allow us 24-48 hours to return your call answering routine questions. **If it is an urgent matter during business hours, do not leave a voice message but rather communicate your needs directly to office staff.** Our regular office hours for phone calls are 8:30am-4:30pm Monday through Thursday and Fridays 9am-3pm. After regular office hours, please utilize our voice mail system following the prompted instructions given.

Prescription Refill Requests

Please do not wait till the last minute to request refills on prescription. We require a minimum of 72 hours to refill prescriptions and cannot guarantee refills will be granted in less time. Refill requests should be left with the nurse by following the telephone prompts. Prescription refills will be considered by the medical staff for active patients only. For most prescription refills, your last appointment must not be more than 6 months prior to your request. Patients who have not been seen for a year or more must make a follow up appointment in order to receive new or refilled prescriptions.

Letters/Forms

Disability forms, social security forms, etc. are very complex and require time. There may be a $25 fee for completing such forms. Please try to request letters relating to work and/or school from your provider at the time of your visit, when possible, and allow up to 2 weeks for turnaround. For release of medical records, please allow 10-14 days from the time your written request is received by our office for your request to be processed and completed. This request must be signed by you, authorizing us to release medical information. Please note, we only send medical information originating from our office, ie: your practitioner's medical office notes and/or labs ordered by him/her.

Thank you for your understanding and cooperation. Please contact the Office Manager at (802)445-3152 with any questions or concerns.

Stram Center for Integrative Medicine

Patient Compliance Agreement

The care a patient receives depends partially on the patient. Patients have a responsibility to provide accurate and complete information concerning his/her present complaints, past medical history, and other matters relating to his/her health. The patient is responsible for making it known whether he/she clearly comprehends the course of his/her medical treatment and what is expected of him/her.

I, _____, (Print Name of Patient or Parents) as either a patient OR as parent of a minor child, agree to comply with the treatment protocols and recommendations of the Stram Center medical staff in order to get the best outcome of the recommended treatment. As part of my compliance agreement, I further agree to make an appointment if I have any questions regarding my treatment or my child's treatment or protocols. If at any time I disagree with the treatment or protocols that the Stram Center medical staff has advised, or am experiencing adverse reactions, I will communicate that by contacting the office in a timely fashion.

I further acknowledge the Stram Center medical staff is seeing scheduled patients during the day, and there is not always ample time to take my call directly regarding routine questions. I will leave a detailed message with one of the office staff or on the medical voicemail line. I agree and understand that I am to allow up to 48 hours for a return call regarding these questions. More importantly, I agree that if it is an urgent matter during business hours I will not leave a voice message but rather communicate my needs directly to the office staff.

STATEMENT REGARDING CRISIS MANAGEMENT AND EMERGENCY MEDICAL CARE:
I understand that the Stram Center for Integrative Medicine does not provide physical or mental health crisis management. I understand if I am experiencing a physical or mental health crisis I must obtain service that are appropriate to the type of crisis I am experiencing. If I am experiencing severe, acute symptoms or feel a life threatening illness I will call:

- 911
- My local hospital emergency room
- My local police or fire department
- Albany County Mobile Crisis Team 518-447-9650 (Mental or emotional distress)

Patient Name:_____

Patient Signature:_____

Date:_____

Stram Center Therapeutic Agreements

STATEMENT OF COLLABORATION

As a Stram Center 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 Stram Center patient, 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 Stram Center 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 Stram Center practitioner(s)
Work together with my Stram Center 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 Stram Center patient, I understand that what I discuss with my Stram Center 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 Stram Center 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 Registry
- Inform someone close to the client if they feel the client might harm him/herself or anyone else

Stram Center practitioners believe that the concept of integrative medicine works best when Stram Center 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 Stram Center 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.

STATEMENT REGARDING CRISIS MANAGEMENT AND EMERGENCY MEDICAL CARE:

I understand that the Stram Center for Integrative Medicine does not provide physical or mental health crisis management. I understand if I am experiencing a physical or mental health crisis I must obtain service that are appropriate to the type of crisis I am experiencing. If I am experiencing severe, acute symptoms or feel a life threatening illness I will call:

- 911
- My local hospital emergency room
- My local police or fire department

Finally, I have read and understand all of the forms contained within this patient packet.

Client Signature:_____ Date: _____