Date of First Visit (mm/dd/yy):_____

BUTTERFLY
NATUROPATHIC

Butterfly Naturopathic
Medical Clinic
1721 Lonsdale Ave.
North Vancouver, BC
(604) 980-8885

info@butterflynaturopathic.com

All patient information within this form is strictly confidential.

*Please fill out this form and email it to our office before your first appointment.

This form can be filled out electronically or printed out and handwritten.

First Name: _____ Last Name: _____

Date of birth (mm/dd/yy):_____ City of Birth: _____

Province/State & Country of birth:_____

ADDRESS:_____ CITY: _____

Province/State: _____ Postal Code: _____

Personal Health No. (Care Card #): _____

Are you on Premium assistance? ■ YES ☐ NO

Do you have an extended health care plan? ■ YES ☐ NO

Do you currently have an active ICBC or WBC claim? ■ YES ☐ NO

CELL#: _____ WORK#: _____

HOME#: _____ OCCUPATION: _____

EMAIL: _____ EMPLOYER: _____

Marital Status: Married Number of Children:_____

EMERGENCY CONTACT

NAME: _____ Cell# _____ Work# _____

Home #:_____Relationship: _____

**Healthcare Providers:**

| Practitioner's Name | Designation/Specialty | Phone | Fax |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Date of last visit with GP (mm/dd/yy):_____ Date of last Full Physical Exam(mm/dd/yy):_____

Have you seen a Naturopathic Doctor before? ☐ YES ☐ NO When? _____ Dr. _____

How did you hear about our clinic? _____

Would you like to receive our periodic news bulletins from us via email? ■ YES ☐ NO

Are you comfortable with needles? ☐ YES ☐ NO If no, explain: _____

Have you ever fainted at the sight of blood? ■ YES ☐ NO

Have you ever had a spinal manipulation/chiropractic adjustment? ■ YES ☐ NO

Do you have a pacemaker? ■ YES ☐ NO How many metal fillings do you have? _____

How <u>often</u> have you been treated with antibiotics in your lifetime? _____

Are you pregnant? ■ YES ☐ NO If yes, how many weeks? _____

Date of First Visit (mm/dd/yy):_____

## YOUR HEALTH

Please list your health concerns in order of importance:

| | Health Concerns | When did it start? | Formal Diagnosis? | What have you tried? (Treatments) |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |

## PRESCRIPTION MEDICATIONS

| Name/Brand | Purpose | Prescribed by | Dose | Date Started |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## SUPPLEMENTS

| Name/Brand | Purpose | Prescribed by | Dose | Date Started |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## ALLERGIES & SENSITIVITIES

**Life Threatening Allergies**

| Substance | Symptoms |
|---|---|
| | |
| | |
| | |
| | |

**Food Allergy/Sensitivities**

| Substance | Symptoms |
|---|---|
| | |
| | |
| | |
| | |

**Environmental Allergy/Sensitivities**

| Substance | Symptoms |
|---|---|
| | |
| | |
| | |
| | |

Have you ever experienced adverse effects from vaccinations? ■ YES ☐ NO

If Yes, please explain: _____

Date of First Visit (mm/dd/yy):_____

**Surgeries & Hospitalizations**

Please list major surgeries, accidents, & hospitalizations:

| Date | Event |
|---|---|
| | |
| | |
| | |
| | |
| | |

## GOALS & VALUES

What expectations do you have for your visits to our clinic?

What are your short term health goals?

What are your long term health goals?

What behaviours or lifestyle choices do you believe SUPPORT your health?

What habits, behaviours, and thought patterns PREVENT you from achieving your health goals?

On a scale of 0-5, what is your current level of commitment to addressing your health issues? 0_____

0 = Not currently willing to make any changes 5 = Complete willingness to make any changes and do whatever is necessary

What potential obstacles might prevent you from following suggestions related to changing your diet, exercise regimen, or other lifestyle choices?

How do you spend most of your time & energy?

What do you think about or focus on the most?

What inspires you? What are you passionate about?

What would you do if you had more time and were healthier?

What areas in your life are the most organized?

What do you most love to do?

# SYMPTOM CHECK

C = Current P = Past If Past, please indicate age

## General

| | | | | | |
|---|---|---|---|---|---|
| Insomnia | ☐ C ☐ P Age: __ | No Appetite | ☐ C ☐ P Age: __ | Chills | ☐ C ☐ P Age: __ |
| Fatigue | ☐ C ☐ P Age: __ | Weight gain | ☐ C ☐ P Age: __ | Night Sweats | ☐ C ☐ P Age: __ |
| Very Thirsty | ☐ C ☐ P Age: __ | Weight loss | ☐ C ☐ P Age: __ | Excessive Sweat | ☐ C ☐ P Age: __ |
| Cravings | ☐ C ☐ P Age: __ | Easy Bleeding | ☐ C ☐ P Age: __ | Fever | ☐ C ☐ P Age: __ |
| Overeating | ☐ C ☐ P Age: __ | Easy Bruising | ☐ C ☐ P Age: __ | Sudden Energy drop | ☐ C ☐ P Age: __ |
| Tremors | ☐ C ☐ P Age: __ | Fainting | ☐ C ☐ P Age: __ | Poor Balance | ☐ C ☐ P Age: __ |

## Skin & Hair

| | | | | | |
|---|---|---|---|---|---|
| Rashes | ☐ C ☐ P Age: __ | Eczema | ☐ C ☐ P Age: __ | Change in hair texture | ☐ C ☐ P Age: __ |
| Hives | ☐ C ☐ P Age: __ | Acne | ☐ C ☐ P Age: __ | Hair loss | ☐ C ☐ P Age: __ |
| Itching | ☐ C ☐ P Age: __ | Recent Moles | ☐ C ☐ P Age: __ | Dandruff | ☐ C ☐ P Age: __ |
| Skin ulcers | ☐ C ☐ P Age: __ | Mole changes | ☐ C ☐ P Age: __ | | |

Other Skin or Hair symptoms: _____

## Head, Eyes, Ears, Nose, & Throat

| | | | | | |
|---|---|---|---|---|---|
| Headaches | ☐ C ☐ P Age: __ | Blurred vision | ☐ C ☐ P Age: __ | Corrective lenses | ☐ C ☐ P Age: __ |
| Migraines | ☐ C ☐ P Age: __ | Cataracts | ☐ C ☐ P Age: __ | Night blindness | ☐ C ☐ P Age: __ |
| Neck pain | ☐ C ☐ P Age: __ | Colour blind | ☐ C ☐ P Age: __ | Lip or tongue pain | ☐ C ☐ P Age: __ |
| Concussions | ☐ C ☐ P Age: __ | Eye pain | ☐ C ☐ P Age: __ | Hearing loss | ☐ C ☐ P Age: __ |
| Dizziness | ☐ C ☐ P Age: __ | Floaters | ☐ C ☐ P Age: __ | Ringing in ears | ☐ C ☐ P Age: __ |
| Jaw clicks | ☐ C ☐ P Age: __ | Ear infections | ☐ C ☐ P Age: __ | Nosebleeds | ☐ C ☐ P Age: __ |
| Jaw pain | ☐ C ☐ P Age: __ | Earaches | ☐ C ☐ P Age: __ | Nasal Congestion | ☐ C ☐ P Age: __ |
| Teeth grinding | ☐ C ☐ P Age: __ | Tooth pain | ☐ C ☐ P Age: __ | Recurring Sore throats | ☐ C ☐ P Age: __ |

Other Head, Eyes, Ears, Nose, & Throat symptoms: _____

## Heart & Circulation

| | | | | | |
|---|---|---|---|---|---|
| Chest Pain | ☐ C ☐ P Age: __ | Cold hands | ☐ C ☐ P Age: __ | High Blood Pressure | ☐ C ☐ P Age: __ |
| Swollen Feet | ☐ C ☐ P Age: __ | Cold feet | ☐ C ☐ P Age: __ | Low Blood Pressure | ☐ C ☐ P Age: __ |
| Blood Clots | ☐ C ☐ P Age: __ | Varicose veins | ☐ C ☐ P Age: __ | Irregular heartbeat | ☐ C ☐ P Age: __ |

Other Heart & Circulation symptoms: _____

## Lungs & Breathing

| | | | | | |
|---|---|---|---|---|---|
| Cough | ☐ C ☐ P Age: __ | Bronchitis | ☐ C ☐ P Age: __ | Difficulty breathing | ☐ C ☐ P Age: __ |
| Coughing blood | ☐ C ☐ P Age: __ | Asthma | ☐ C ☐ P Age: __ | Pain with breathing | ☐ C ☐ P Age: __ |
| Coughing phlegm | ☐ C ☐ P Age: __ | Pneumonia | ☐ C ☐ P Age: __ | Wheezing | ☐ C ☐ P Age: __ |

Other Lung & Breathing symptoms: _____

## Digestion & Elimination

| | | | | | |
|---|---|---|---|---|---|
| Nausea | ☐ C ☐ P Age: __ | Constipation | ☐ C ☐ P Age: __ | Abdominal pain | ☐ C ☐ P Age: __ |
| Vomiting | ☐ C ☐ P Age: __ | Rectal pain | ☐ C ☐ P Age: __ | Bad Breath | ☐ C ☐ P Age: __ |
| Blood in stool | ☐ C ☐ P Age: __ | Gas | ☐ C ☐ P Age: __ | Bloating | ☐ C ☐ P Age: __ |
| Diarrhea | ☐ C ☐ P Age: __ | Heart Burn | ☐ C ☐ P Age: __ | Chronic laxative use | ☐ C ☐ P Age: __ |
| Excess Burping | ☐ C ☐ P Age: __ | Indigestion | ☐ C ☐ P Age: __ | Hemorrhoids | ☐ C ☐ P Age: __ |

Other Digestion & Elimination symptoms: _____

## Urinary

| | | | | | |
|---|---|---|---|---|---|
| Pain on urination | ☐ C ☐ P Age: __ | Blood in urine | ☐ C ☐ P Age: __ | Sores on genitals | ☐ C ☐ P Age: __ |
| Dark Urine | ☐ C ☐ P Age: __ | Decrease in flow | ☐ C ☐ P Age: __ | Unable to hold urine | ☐ C ☐ P Age: __ |
| Waking to urinate | ☐ C ☐ P Age: __ | Frequent Urination | ☐ C ☐ P Age: __ | Urgency to urinate | ☐ C ☐ P Age: __ |
| Kidney Stones | ☐ C ☐ P Age: __ | Urinary Tract Infections | ☐ C ☐ P Age: __ | Loss of bladder control | ☐ C ☐ P Age: __ |

Other Urinary symptoms: _____

## Muscles, Joints, & Bones

| | | | | | |
|---|---|---|---|---|---|
| Back pain | ☐ C ☐ P Age: __ | Hip pain | ☐ C ☐ P Age: __ | Joint Pain | ☐ C ☐ P Age: __ |
| Neck pain | ☐ C ☐ P Age: __ | Knee pain | ☐ C ☐ P Age: __ | Muscle weakness | ☐ C ☐ P Age: __ |
| Shoulder pains | ☐ C ☐ P Age: __ | Foot /ankle pain | ☐ C ☐ P Age: __ | Muscle pain | ☐ C ☐ P Age: __ |
| Hand wrist pain | ☐ C ☐ P Age: __ | Weak bones | ☐ C ☐ P Age: __ | Bone Pain | ☐ C ☐ P Age: __ |

Other Muscle, Joints, & Bone symptoms: _____

## Brain, Nerves, Emotions

| | | | | | |
|---|---|---|---|---|---|
| Anxiety | ☐ C ☐ P Age: __ | Numbness | ☐ C ☐ P Age: __ | Lack of coordination | ☐ C ☐ P Age: __ |
| Depression | ☐ C ☐ P Age: __ | Shooting Pain | ☐ C ☐ P Age: __ | Poor balance | ☐ C ☐ P Age: __ |
| Stress | ☐ C ☐ P Age: __ | Twitching | ☐ C ☐ P Age: __ | Poor memory | ☐ C ☐ P Age: __ |
| Irritable | ☐ C ☐ P Age: __ | Seizures | ☐ C ☐ P Age: __ | Psychiatric diagnosis | ☐ C ☐ P Age: __ |
| Temper/Rage | ☐ C ☐ P Age: __ | Tremors | ☐ C ☐ P Age: __ | Suicidal thoughts | ☐ C ☐ P Age: __ |

Other Brain, Nerve, or Emotional symptoms: _____

## Women's Health

| | | | | | |
|---|---|---|---|---|---|
| Heavy menses | ☐ C ☐ P Age: __ | Light Menses | ☐ C ☐ P Age: __ | Premenstrual changes | ☐ C ☐ P Age: __ |
| Mood swings | ☐ C ☐ P Age: __ | Irregular Menses | ☐ C ☐ P Age: __ | Gestational Diabetes | ☐ C ☐ P Age: __ |
| Menstrual clots | ☐ C ☐ P Age: __ | Endometriosis | ☐ C ☐ P Age: __ | Nipple discharge | ☐ C ☐ P Age: __ |
| Painful Menses | ☐ C ☐ P Age: __ | Hot flashes | ☐ C ☐ P Age: __ | Breast lumps | ☐ C ☐ P Age: __ |
| Vaginal dryness | ☐ C ☐ P Age: __ | Night sweats | ☐ C ☐ P Age: __ | Fibrocystic breasts | ☐ C ☐ P Age: __ |
| Uterine Fibroids | ☐ C ☐ P Age: __ | Ovarian cysts | ☐ C ☐ P Age: __ | Pain on intercourse | ☐ C ☐ P Age: __ |
| Cervical dysplasia | ☐ C ☐ P Age: __ | Infertility | ☐ C ☐ P Age: __ | Low sex drive | ☐ C ☐ P Age: __ |

# of sexual partners in the last year _____

# of pregnancies: _____

Sexually transmitted infections (list with year) _____

Age of first menses: _____

# of abortions: _____

Type of birth control used _____

Date of last PAP? (mm/dd/yy) _____

# of caesareans: _____

Date of last menses: (mm/dd/yy) _____

No. of abnormal PAPs? _____

# of births: _____

How long is your cycle? _____ days

Date of last mammogram? (mm/dd/yy) _____

# of miscarriages: _____

How many days of bleeding? _____ days

Do you do self breast exams? ☐ Y ☐ N

# of children breast fed _____

Are you on hormone replacement therapy? ☐ Y ☐ N If Yes, since when? _____

Other Women's Health symptoms: _____

## Family Medical History

| Family member | Medical Conditions | Age | Deceased (Y/N) Age at Death? Cause of Death? |
|---|---|---|---|
| Father | | | |
| Mother | | | |
| Brother(s) | | | |
| Sister(s) | | | |
| Son(s) | | | |
| Daughter(s) | | | |
| Paternal GF | | | |
| Paternal GM | | | |
| Maternal GF | | | |
| Maternal GM | | | |

## Lifestyle

How often do you exercise each week? (20min of sweating with an increased heart rate): _____

Do you follow a special diet? ☐ Y ☐ N If yes, please describe: _____

What foods do you avoid? _____

How many packs of cigarettes do you smoke per day? _____ How many years have you smoked? _____

What stress factors do you encounter at work? (mental, social, physical, chemical) _____

_____

How many caffeinated products do you consume each day? _____ What kind? _____

How many alcoholic drinks do you consume each week? _____ What kind? _____

Please list any recreational drug use: _____

What sugar containing products do you consume? _____ How often? _____

Have you ever felt sad or depressed for 2 weeks or more in the past year? ☐ Y ☐ N

**Please rate the following on a scale of 0 to 10, 0 = lowest & 10 = highest:**

Overall stress level? 0 Overall energy level? 0 How Happy are you? 0