

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



BUTTERFLY
NATUROPATHIC

Butterfly Naturopathic
Medical Clinic
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North Vancouver, BC
(604) 980-8885

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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: _____ 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 often have you been treated with antibiotics in your lifetime? _____

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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: _____

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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 = 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 <input type="checkbox"/> C <input type="checkbox"/> P Age: __	No Appetite <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Chills <input type="checkbox"/> C <input type="checkbox"/> P Age: __
Fatigue <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Weight gain <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Night Sweats <input type="checkbox"/> C <input type="checkbox"/> P Age: __
Very Thirsty <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Weight loss <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Excessive Sweat <input type="checkbox"/> C <input type="checkbox"/> P Age: __
Cravings <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Easy Bleeding <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Fever <input type="checkbox"/> C <input type="checkbox"/> P Age: __
Overeating <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Easy Bruising <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Sudden Energy drop <input type="checkbox"/> C <input type="checkbox"/> P Age: __
Tremors <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Fainting <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Poor Balance <input type="checkbox"/> C <input type="checkbox"/> P Age: __

Skin & Hair

Rashes <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Eczema <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Change in hair texture <input type="checkbox"/> C <input type="checkbox"/> P Age: __
Hives <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Acne <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Hair loss <input type="checkbox"/> C <input type="checkbox"/> P Age: __
Itching <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Recent Moles <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Dandruff <input type="checkbox"/> C <input type="checkbox"/> P Age: __
Skin ulcers <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Mole changes <input type="checkbox"/> C <input type="checkbox"/> P Age: __	

Other Skin or Hair symptoms: _____

Head, Eyes, Ears, Nose, & Throat

Headaches <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Blurred vision <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Corrective lenses <input type="checkbox"/> C <input type="checkbox"/> P Age: __
Migraines <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Cataracts <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Night blindness <input type="checkbox"/> C <input type="checkbox"/> P Age: __
Neck pain <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Colour blind <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Lip or tongue pain <input type="checkbox"/> C <input type="checkbox"/> P Age: __
Concussions <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Eye pain <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Hearing loss <input type="checkbox"/> C <input type="checkbox"/> P Age: __
Dizziness <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Floater <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Ringing in ears <input type="checkbox"/> C <input type="checkbox"/> P Age: __
Jaw clicks <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Ear infections <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Nosebleeds <input type="checkbox"/> C <input type="checkbox"/> P Age: __
Jaw pain <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Earaches <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Nasal Congestion <input type="checkbox"/> C <input type="checkbox"/> P Age: __
Teeth grinding <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Tooth pain <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Recurring Sore throats <input type="checkbox"/> C <input type="checkbox"/> P Age: __

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

Heart & Circulation

Chest Pain <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Cold hands <input type="checkbox"/> C <input type="checkbox"/> P Age: __	High Blood Pressure <input type="checkbox"/> C <input type="checkbox"/> P Age: __
Swollen Feet <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Cold feet <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Low Blood Pressure <input type="checkbox"/> C <input type="checkbox"/> P Age: __
Blood Clots <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Varicose veins <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Irregular heartbeat <input type="checkbox"/> C <input type="checkbox"/> P Age: __

Other Heart & Circulation symptoms: _____

Lungs & Breathing

Cough <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Bronchitis <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Difficulty breathing <input type="checkbox"/> C <input type="checkbox"/> P Age: __
Coughing blood <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Asthma <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Pain with breathing <input type="checkbox"/> C <input type="checkbox"/> P Age: __
Coughing phlegm <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Pneumonia <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Wheezing <input type="checkbox"/> C <input type="checkbox"/> P Age: __

Other Lung & Breathing symptoms: _____

Digestion & Elimination

Nausea <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Constipation <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Abdominal pain <input type="checkbox"/> C <input type="checkbox"/> P Age: __
Vomiting <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Rectal pain <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Bad Breath <input type="checkbox"/> C <input type="checkbox"/> P Age: __
Blood in stool <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Gas <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Bloating <input type="checkbox"/> C <input type="checkbox"/> P Age: __
Diarrhea <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Heart Burn <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Chronic laxative use <input type="checkbox"/> C <input type="checkbox"/> P Age: __
Excess Burping <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Indigestion <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Hemorrhoids <input type="checkbox"/> C <input type="checkbox"/> P Age: __

Other Digestion & Elimination symptoms: _____

Urinary

Pain on urination <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Blood in urine <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Sores on genitals <input type="checkbox"/> C <input type="checkbox"/> P Age: __
Dark Urine <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Decrease in flow <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Unable to hold urine <input type="checkbox"/> C <input type="checkbox"/> P Age: __
Waking to urinate <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Frequent Urination <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Urgency to urinate <input type="checkbox"/> C <input type="checkbox"/> P Age: __
Kidney Stones <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Urinary Tract Infections <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Loss of bladder control <input type="checkbox"/> C <input type="checkbox"/> P Age: __

Other Urinary symptoms: _____

Muscles, Joints, & Bones

Back pain <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Hip pain <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Joint Pain <input type="checkbox"/> C <input type="checkbox"/> P Age: __
Neck pain <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Knee pain <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Muscle weakness <input type="checkbox"/> C <input type="checkbox"/> P Age: __
Shoulder pains <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Foot /ankle pain <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Muscle pain <input type="checkbox"/> C <input type="checkbox"/> P Age: __
Hand wrist pain <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Weak bones <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Bone Pain <input type="checkbox"/> C <input type="checkbox"/> P Age: __

Other Muscle, Joints, & Bone symptoms: _____

Brain, Nerves, Emotions

Anxiety <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Numbness <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Lack of coordination <input type="checkbox"/> C <input type="checkbox"/> P Age: __
Depression <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Shooting Pain <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Poor balance <input type="checkbox"/> C <input type="checkbox"/> P Age: __
Stress <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Twitching <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Poor memory <input type="checkbox"/> C <input type="checkbox"/> P Age: __
Irritable <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Seizures <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Psychiatric diagnosis <input type="checkbox"/> C <input type="checkbox"/> P Age: __
Temper/Rage <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Tremors <input type="checkbox"/> C <input type="checkbox"/> P Age: __	Suicidal thoughts <input type="checkbox"/> C <input type="checkbox"/> P Age: __

Other Brain, Nerve, or Emotional symptoms: _____

Men's Health

Penile discharge	<input type="checkbox"/> C <input type="checkbox"/> P Age: __	Testicular pain	<input type="checkbox"/> C <input type="checkbox"/> P Age: __	Testicular masses	<input type="checkbox"/> C <input type="checkbox"/> P Age: __
Sores on genitals	<input type="checkbox"/> C <input type="checkbox"/> P Age: __	Hernias	<input type="checkbox"/> C <input type="checkbox"/> P Age: __	Prostate disease	<input type="checkbox"/> C <input type="checkbox"/> P Age: __
Low sperm count	<input type="checkbox"/> C <input type="checkbox"/> P Age: __	Date of last Prostate Exam:	_____	Erectile Dysfunction	<input type="checkbox"/> C <input type="checkbox"/> P Age: __
# of sexual partners in the last year	_____	Type of birth control used	_____	Sexually transmitted infections (list with year)	_____ _____ _____

Surgeries & Hospitalizations

Please list major surgeries, accidents, & hospitalizations:

Date	Event

Family Medical History

Family member	Medical Conditions	Age	Deceased (Y/N) Cause of Death?	Age at 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? _____ Overall energy level? _____ How Happy are you? _____