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: _____________________ 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? _____________________________

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 = 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

Symptom	Status	Symptom	Status	Symptom	Status
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

Symptom	Status	Symptom	Status	Symptom	Status
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

Symptom	Status	Symptom	Status	Symptom	Status
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

Symptom	Status	Symptom	Status	Symptom	Status
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

Symptom	Status	Symptom	Status	Symptom	Status
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

Symptom	Status	Symptom	Status	Symptom	Status
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

Symptom	Status	Symptom	Status	Symptom	Status
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

Symptom	Status	Symptom	Status	Symptom	Status
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

Symptom	Status	Symptom	Status	Symptom	Status
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

Symptom	C	P	Age	Symptom	C	P	Age	Symptom	C	P	Age
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? _____ Overall energy level? _____ How Happy are you? _____