

Date of First Visit (mm/dd/yy): \_\_\_\_\_



**BUTTERFLY**  
NATUROPATHIC

Butterfly Naturopathic  
Medical Clinic  
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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? \_\_\_\_\_

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): \_\_\_\_\_

## 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? \_\_\_\_\_