

Dr. Sara Kinnon
Bellevue Natural Health Clinic
1467 Bellevue Avenue
West Vancouver, BC
V7T 1C3

Personal Information

Name: _____ Date of First Visit: _____ MSP # _____
Address: _____ City, Province: _____ Postal code: _____
Telephone # (home): _____ Telephone # (work): _____

Email address: _____ Birthday: _____ Age: _____
Occupation: _____

Are you: Single Partnership Married Separated Divorced Widowed
Live with: Alone Partner Parents Friends Children Relatives

Emergency Contact

Name: _____ Relationship: _____ Phone #: _____

How did you hear about Dr Kinnon? _____
Do you currently have an active ICBC or WCB claim? _____
Are you on Premium Assistance (MSP)? _____

List your **current health care providers** (includes medical doctors, chiropractors, counselors, massage, physiotherapist, acupuncturist)

Name	Profession
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do you have any known contagious diseases at this time?

No Yes, what? _____

Email Correspondence (your email will never be sold, shared or traded)

Would you like to receive a copy of my newsletter via email? No Yes

Consent

I hereby consent to naturopathic treatment from Dr Kinnon. I understand this consent is voluntary and may be revoked at any time. I accept responsibility for prompt payment for therapies provided.

Signed: _____ Date: _____

Health Overview - *Comprehensive health care requires a complete picture of your health. Please take the time to complete this questionnaire carefully. If you are unsure about a question, mark it and we can discuss it during the visit.*

What are your most important health problems? List as many as you can, in order of importance to you.

1. _____
2. _____
- _____
- _____
- _____
3. _____

Family History

___ - I don't know my family history (skip to next section)

	Mother	Father	Sibling(s)	Grand-parent	Children	Spouse
Age, if living						
Age at death						
Cause of death						
Check all that apply:						
Glaucoma						
High blood pressure						
Asthma						
HIV/AIDS						
Tuberculosis						
Cancer (list type)						
Diabetes						
Epilepsy						
Stroke						
Heart disease						
Allergies						
Thyroid problems						
Osteoporosis						
Other (please list)						

Childhood illnesses (Check all that apply)

Chicken pox Mumps Measles Rubella Whooping cough
 Diphteria Scarlet fever Asthma Others: _____

Immunization history (Check all that apply)

Tetanus Measles/mumps/rubella Pertussis Diphteria Hepatitis A
 Hepatitis B Polio Flu shot Others: _____

List known allergies or sensitivities:

Foods: _____
 Medications: _____
 Environmental factors: _____
 Chemicals: _____

Do you currently take or use:

Laxatives Pain relievers Antacids Cortisone Sleeping pills
Antibiotics Anti-depressants Hormones Birth control pills/patch/shot

List all current medications with dosages:

Prescription medications: _____

Over the counter medications: _____

Supplements: _____

Natural remedies (herbal, homeopathic): _____

What accidents/traumas have you had?

What hospitalizations or surgeries have you had?

What medical tests (x-rays, CT scans, MRI, ECG) have you had?

General Information

Current height: _____

Current weight: _____

What time of day is your energy best? _____

Worst? _____

Review of Systems: Check all continuing or recurrent problems

General

- Weight loss
- Weight gain
- Fatigue
- Sleep disturbance

- Tension
- Poor concentration
- Memory problems

Endocrine

- Thyroid problem
- Heat or cold intolerance
- Hypoglycemia
- Diabetes
- Excessive thirst
- Excessive hunger
- Fatigue
- Seasonal depression_

Immune

- Reactions to vaccinations
- Chronic Fatigue Syndrome
- Chronic infections
- Chronically swollen glands
- Slow wound healing

Neurologic

- Seizures/epilepsy
- Paralysis

Mental / Emotional

- Depression
- Mood Swings
- Anxiety or nervousness
- Considered/Attempted suicide

- Muscle weakness
- Numbness or tingling

- Loss of memory
- Easily stressed
- Vertigo or dizziness
- Loss of balance

Skin

- Rashes
- Eczema, Hives
- Acne
- Boils
- Itching
- Color Change
- Hair Loss
- Lumps
- Dry or scaling
- Night Sweats
- Excessive or no sweat

Head

- Headaches
- Head Injury
- Migraines
- Jaw/TMJ problems
- Fainting

Ears

- Hearing loss
- Ringing
- Earaches
- Dizziness
- Sensitivity to noise

Discharge from ears_

Nose and Sinuses

- Frequent colds
- Nose Bleeds

- Stuffiness
- Hayfever
- Sinus problems
- Loss of smell

Eyes

- Glasses or contacts
- Color blind
- Double Vision
- Spots in eyes
- Recent change in vision
- Blurred vision
- Eye pain/strain
- Sensitive to light
- Eyes water excessively
- Bloodshot or puffy eyes
- Dryness

Mouth and Throat

- Frequent sore throat
- Copious saliva
- Teeth grinding
- Mouth ulcers
- Sore tongue/lips
- Gum problems
- Hoarseness
- Loss of voice
- Dental cavities
- Jaw clicks
- Cold sores

Neck

- Lumps
- Swollen glands
- Goiter
- Pain or stiffness

Cardiovascular

- Heart disease

- High/Low Blood Pressure
- Murmurs
- Blood clots
- Fainting
- Phlebitis
- Palpitations/Fluttering
- Rheumatic Fever
- Chest pain
- Swelling in ankles

Respiratory

- Cough
- Sputum (mucus)
- Spitting up blood
- Wheezing
- Painful breathing
- Emphysema
- Difficulty breathing
- Pain on breathing
- Shortness of breath
- Shortness of breath lying down

Gastrointestinal

- Bowel Movements: How often? _____
- Is this a change? _____
- Constipation
- Diarrhea
- Trouble swallowing
- Heartburn
- Change in thirst
- Change in appetite
- Abdominal pain or cramps
- Belching or passing gas
- Nausea/vomiting
- Hemorrhoids
- Black stools
- Blood or mucus stool
- Undigested food in stool
- Ulcer
- Jaundice (yellow skin)

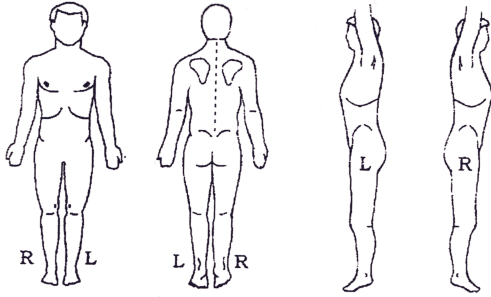
Urinary

- Pain on urination
- Increased frequency
- Frequency at night
- Inability to hold urine
- Blood in urine
- Difficulty starting to urinate
- Frequent infections
- Kidney stones

Musculoskeletal

- Joint pain or stiffness
- Broken bones
- Muscle weakness
- Muscle spasms or cramps
- Sciatica

- Mark areas you currently feel pain:



- Recent changes in breasts
- Breast lumps
- Breast pain/tenderness
- Nipple discharge
- Date of last annual exam/PAP _____
- Any abnormal PAPs? No Yes, when: _____
- Age of first menses? _____

Blood / Peripheral Vascular

- Easy bleeding or bruising
- Anemia
- Deep leg pain
- Cold hands/feet
- Varicose veins
- Thrombophlebitis
- Fluid retention

Male Reproduction

- Hernias
- Testicular masses
- Testicular pain
- Do you do testicular self-exam?
- Prostate problems
- Venereal disease
- Discharge or sores
- Are you sexually active? No Yes
- Birth control? No Yes, type: _____
- Erectile dysfunction
- Low libido
- Premature ejaculation
- Sexually transmitted infection

- Are you sexually active?
- Low libido
- Pain during intercourse
- Sexually transmitted infection

Fill in this section if pre-menopausal:

- Irregular or no cycle:
- Duration of menses: _____ days
- Length of cycle: _____ days
- Bleeding between cycles
- Abnormal bleeding
- Painful menses
- Clotting
- Heavy or excessive flow
- Discharge
- PMS
- Birth control? No Yes, type: _____
- Difficulty conceiving
- Perimenopausal

Fill this section if menopausal:

- Age of last menses
- Any menopausal symptoms?
- Vaginal bleeding since menopause

Female Reproduction / Breasts

- Do you do breast self-exams?

Lifestyle

How often do you eat out? _____

How often do you consume:

Coffee _____

Pop _____

Sugar _____

Added salt _____

Alcohol _____

Recreational drugs _____

Tobacco _____

Artificial sweeteners _____

What are your main interests and hobbies? _____

What exercise do you do and how often? _____

How many hours sleep do you get? _____

Do you awake feeling rested? _____

Do you have supportive relationships? _____

Do you have any occupational hazards? _____

Have you ever been treated for an addiction? _____

Smoked previously? How many years? How many packs per day? _____

Do you have a religious or spiritual practice? _____

Is there anything else you would like to add or comment on?

Context of Care

Why did you choose to come to this clinic?

What long term expectations do you have?

What expectations do you have of me as your naturopathic physician?

What is your current level of commitment to addressing your health issues?

- I am willing to make any changes and do whatever in necessary
- I am willing to make some changes in my lifestyle to feel better
- I may consider change if absolutely necessary to feel better
- I am specifically looking for a medication/surgical alternative
- I am here to learn more about my healthcare options and what you offer

Thank you for taking the time to fill in this information.