

**Dr. Sara Kinnon**  
Lifestyle Health Centre  
#104 8843 204<sup>th</sup> St  
Langley BC V1M 1E6  
604-881-1158

**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						
<b>Check all that apply:</b>						
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)

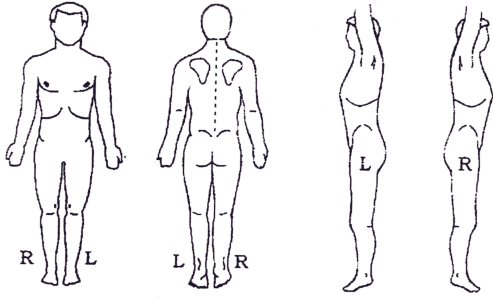
#### Urinary

- 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 \_\_\_\_\_ Alcohol \_\_\_\_\_  
Pop \_\_\_\_\_ Recreational drugs \_\_\_\_\_  
Sugar \_\_\_\_\_ Tobacco \_\_\_\_\_  
Added salt \_\_\_\_\_ 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.*