Dr. Mirjana Baspaly ND, L.Ac.
Naturopathic Physician
Anmore Naturopathic Wellness Centre
3025 Anmore Creek Way, Anmore, BC V3H 5G6
Tel: (778) 885-2153 Email: drbaspaly@naturopathicdr.ca

First Name:_____________________ Last Name:___________________ Date:__________________

Street Address:___________________________________ City:________________

Province:_________ Postal Code:__________ Home phone: ____________Work Phone:____________

Cell Phone:____________ E-mail Address__________________________________

Occupation:______________ Employer______________ Hours work per week:_____ Gender: ____________

Marital Status (circle): Single Married Separated Divorced With Partner Widow(er)

Date of Birth:_________ Age_______ Place of Birth_________________________

Emergency Contact: ___________________Relationship: _________Phone number:___________________

Medical Doctor: _____________________________ MSP No.: _____________________________________

How did you hear about the clinic:________________________________

I understand and agree that I am financially responsible for all charges and payment must be made at the time of visit unless other arrangements are made in advance. I understand and agree that I will pay a fee for the doctor's time if I fail to cancel or reschedule an appointment without 24 hours notice.
Patient's Signature______________________________________ Date________

List in order of importance your main concerns:

1. ____

2. ____

3. ____

4. ____

Allergies/Sensitivities (Please circle allergies):
Drugs: ____

Foods: ____

Environment: ____

Current Medications: ____

Current Supplements: ______________________________

Family History
(Please tick off relevant boxes)

	Father	Mother	Siblings	Grandparents	Spouse	Children
Age if living	______	______	______	______	______	______
Age when died	______	______	______	______	______	______
Reason for death	______	______	______	______	______	______
Cancer (type) ________	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Heart Attack/stroke	☐	☐	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐	☐	☐
Asthma/allergies	☐	☐	☐	☐	☐	☐
Mental illness	☐	☐	☐	☐	☐	☐
TB	☐	☐	☐	☐	☐	☐
Auto-immune disease	☐	☐	☐	☐	☐	☐
Diabetes Mellitus	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐

Extra notes: ______________________________

____

List All Surgeries and Hospitalizations—including date occurred:

1. ______________________ 4. ______________________

2. ______________________ 5. ______________________

3. ______________________ 6. ______________________

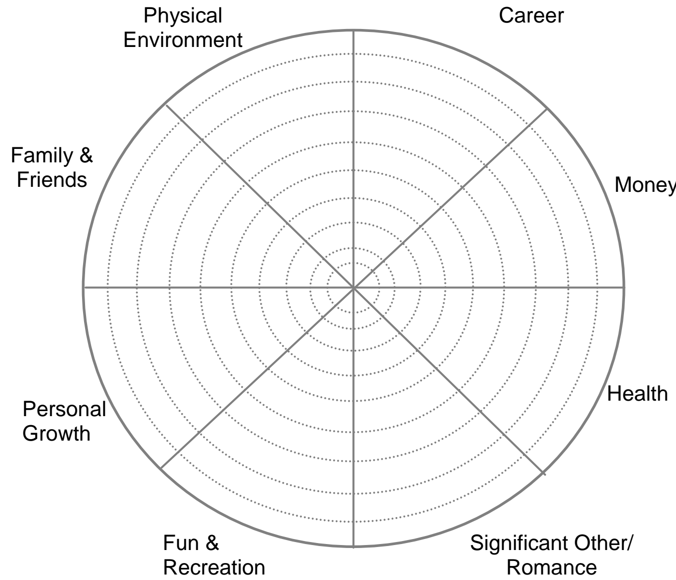
List Yes, No, or Past regarding use of the following:

Antacids:	Y N P	Steroids:	Y N P
Smoking:	Y N P	Packs per day if Yes/Past:__________	
Analgesics:	Y N P	Laxatives:	Y N P
Coffee:	Y N P	Cups per day if Yes/Past:__________	
Soda Pop:	Y N P	Ounces per day if Yes/Past:__________	
Alcohol:	Y N P	How often and how much if Yes/Past:__________	

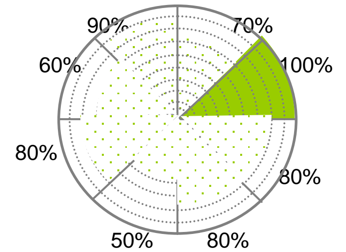
Any alcohol addiction: Y N P
Any alcohol treatment: Y N P
Recreational drugs: Y N P
Any drugs addiction: Y N P
Any drug treatment: Y N P

Wheel of Balance
Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are extremely happy in your career, shade the entire pie shape for career.



Example:



Height: _________ Current Weight: _______lbs. One year ago: __________lbs.

Food:
Appetite Good?: Y N P
Food cravings: ____________________________________
Foods that don't sit well:____________________________
List any foods you avoid: __________________________
List your typical eating habits:
Morning____
Afternoon____
Evening____
How many times a week do you eat out? ______________

Toxin Exposure:
Did you grow up near any refinery, or polluted area, or in home with leaded paint? If so, what sort of pollution were you exposed to?:___________________________________
Have you had any jobs where you were exposed to solvents, heavy metals, fumes, or other toxic materials?:____
Have you ever had health problems when you put in new carpeting, painted your home, had new cabinets, or did other refurbishing?:_______________________________
Are you particularly sensitive to perfumes, gasoline, or other vapors?:________________
Do you use pesticides, herbicides, other chemicals around your home? ______________

Social Life:
Enjoy job?: Y N P
Active Spiritual practice: Y N P
How committed are you towards making valuable changes: Little Moderately Very
Hobbies: ____

Energy /10
When are you low/high?
What makes it better?
What makes it worse?
Do you exercise, what kind? ___________________
How often do you exercise: ___________________

Sleep How many hour per night ________
- ☐ Insomnia
- ☐ Talk/walk/grind teeth
- ☐ Dreams/night terrors
- ☐ Waking in the night
- ☐ Awake refreshed

Temp at night:
Sleeping position:
Dreams:

Body Temp/Weather
Moderate/warm/chilly person
- ☐ Are you affected by weather?
- ☐ Perspiration (excessive)

Thirst
Thirsty/not thirsty
Do you prefer fluids: Cold Warm Hot
How much water do you drink?

Digestion
Bowel movements:
How often: ________
- ☐ Blood/mucus/undigested food in stools
- ☐ Belching/gas/bloating/flatulence
- ☐ Trouble swallowing
- ☐ Heartburn
- ☐ Abdominal pain
- ☐ Parasites
- ☐ Nausea/vomiting
- ☐ Hemorrhoids
- ☐ Eating disorder history
- ☐ Liver/galbladder disease

Head
- ☐ Headaches:
  Pain: /10 Quality:
  How often:
  How long do they last:
- ☐ Injuries:

Eyes
- ☐ Visual problems
- ☐ Photophobia
- ☐ Pain/tearing/dryness

Ears
- ☐ Pain/itching/tinnitus/ringing
- ☐ Hearing loss
- ☐ Wax
- ☐ Dizziness

Nose/sinus
- ☐ Frequent colds/flu
- ☐ Congestion
- ☐ Allergies
- ☐ Discharge
- ☐ Pain/infection/injuries

Mouth/Throat
- ☐ Sore throat
- ☐ Enlarged/tender lymph nodes
- ☐ Mouth sores
- ☐ Swallowing difficulties
- ☐ Bleeding gums/receding gums
- ☐ Toothaches
- ☐ Hoarseness/voice changes
- ☐ Tonsils removed
- ☐ Cavities
- ☐ Dental problems
- ☐ Silver mercury fillings
- ☐ Root canals

Taste in mouth:

Lungs/respiratory
- ☐ Coughs
- ☐ Shortness of breath
- ☐ Tuberculosis (TB)
- ☐ Wheezing
- ☐ Asthma
- ☐ COPD

Heart
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Chest pain
- ☐ Ankle swelling
- ☐ Palpitations/fluttering/irregular beat

Urinary/Kidney
- ☐ Frequency: day/night
- ☐ Urgency
- ☐ Bladder infections
- ☐ Discharge
- ☐ Incontinence
- ☐ Prolapsed
- ☐ Kidney stones

Female
Pregnant: yes/no/maybe

Number of pregnancies:
Number of births: type:
Number of miscarriages:
Emotions associated:
Date of last pap:

- ☐ History of abnormal paps
- ☐ Abnormal discharge
- ☐ History of STD
- ☐ Low libido
- ☐ Menopausal/perimenopausal

Menses

Age of first menses:
Cycle length:
Number of days of bleeding:

- ☐ Clots: colour: size:

Colour of blood:
Excess or low flow:

- ☐ Bleeding between periods
- ☐ Cramping
- ☐ PMS: Tender breasts/Mood swings/cravings/bloating/sleep/ body temp/night sweat

Emotions associated:

Neurological

- ☐ Fainting
- ☐ Seizures
- ☐ Paralysis
- ☐ Numbness/tingling
- ☐ Memory loss
- ☐ Difficulty concentrating

Endocrine

- ☐ Thyroid problems
- ☐ Heat or cold intolerance
- ☐ Blood sugar problems
- ☐ Easy weight gain
- ☐ Diabetes What Type? ____________________

Musculoskeletal

- ☐ Joint pain or stiffness
- ☐ History of broken bones
- ☐ History of motor vehicle accident
- ☐ Surgeries
- ☐ Muscles spasms or cramping
- ☐ Neck pain
- ☐ Back pain
- ☐ Muscle weakness
- ☐ Arthritis: Rhematoid Osteo

Extremities/Circulation

- ☐ Coldness/numbness/tingling in hands/feet or other:
- ☐ Varicose veins
- ☐ Edema

Male

- ☐ Hernia
- ☐ Testicular mass/pain
- ☐ Sexual difficulties
- ☐ Low libido
- ☐ Prostate problems
- ☐ STD's
- ☐ Discharge/sores
- ☐ Difficulty stopping/starting urination

Skin

- ☐ Rashes
- ☐ Eczema
- ☐ Psoriasis
- ☐ Infections
- ☐ Growths
- ☐ Hair/nail changes
- ☐ Dry skin
- ☐ Mole changes
- ☐ Easy bruising
- ☐ Sensitivity

Mental/Emotional

- ☐ Mood swings
- ☐ Irritability
- ☐ Depression
- ☐ Jealousy
- ☐ Anger
- ☐ Anxiety
- ☐ Stressed

Thank you for your time & effort. My aim to provide you with the best possible care.