

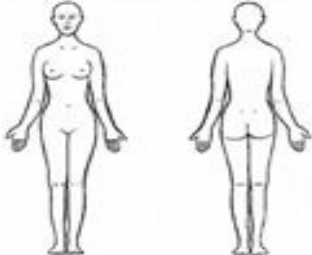
Genesis Forms

Date:

Last name /		First name /		Circle: Mr. Ms. Mrs. Dr.
Birth date /	Age /	Circle # of preferred contact		
Address /		Phone (home) /		
City /		Phone (work) /		
Province /	Postal Code /	Phone (cell) /		
Email /		Occupation /		

Please indicate with a **P** (past) **C** (current) **F** (family) if any of the conditions below apply:

<input type="checkbox"/> Heart conditions	<input type="checkbox"/> Stroke	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Low blood pressure
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Deep vein thrombosis	<input type="checkbox"/> Neurological	<input type="checkbox"/> Haemophiliac
<input type="checkbox"/> Respiratory condition	<input type="checkbox"/> Skin condition	<input type="checkbox"/> Cancer	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> HIV / AIDS	<input type="checkbox"/> Wear a pacemaker	<input type="checkbox"/> Digestive problems	<input type="checkbox"/> Headaches/migraines
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Dizziness/fainting	<input type="checkbox"/> Contagious illness

<p>On the figures below, please circle the areas of concern/pain;</p> <div style="text-align: center;">  </div> <p>Sensations/pain characteristics (check): Sharp ___ Burning ___ Moving ___ Tingling ___ Dull ___ Severe ___ Stabbing ___ Shooting ___ Throbbing ___ Numbness ___</p> <p>What relieves the pain (ice, rest, activity, massage, heat...)? _____</p> <p>What aggravates the pain (weather, heat, cold, rest, activity...)? _____</p>	<p>Please list any prescription medication or over the counter drugs currently taking:</p> <table style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 50%;">1. _____</td><td style="width: 50%;">2. _____</td></tr> <tr><td>3. _____</td><td>4. _____</td></tr> <tr><td>5. _____</td><td>6. _____</td></tr> </table> <p>Please list herbal medicine and other supplements currently taking:</p> <table style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 50%;">1. _____</td><td style="width: 50%;">2. _____</td></tr> <tr><td>3. _____</td><td>4. _____</td></tr> <tr><td>5. _____</td><td>6. _____</td></tr> </table> <p>Have you been hospitalized and/or treated for any infectious/serious conditions or surgeries? If yes, briefly explain for what condition or reasons and the year (below). _____</p> <hr/> <p>Have you been hospitalized and/or treated for any infectious/serious conditions or surgeries? If yes, briefly explain for what condition or reasons and the year (below). _____</p>	1. _____	2. _____	3. _____	4. _____	5. _____	6. _____	1. _____	2. _____	3. _____	4. _____	5. _____	6. _____
1. _____	2. _____												
3. _____	4. _____												
5. _____	6. _____												
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3. _____	4. _____												
5. _____	6. _____												

How did you hear about Acubalance? Genesis, Internet, Friend

Date last menses began / Is your menstrual cycle: Regular ___ Irregular ___

How old were you when you had your first menstruation?	How many days do you bleed in total /
	Menstrual cycle length (i.e. 26-30 days) /

Describe your flow: Heavy ___ Light ___ Average ___	Consistency of blood: Watery ___ Thick ___ Average ___
Does your blood contain clots? Yes ___ No ___ ...and...	At which point during the cycle? Start ___ Mid ___ End ___
Describe the colour of your blood: (red, dark red, brown, purple, brownish red, bright red, pink, etc)	

Do you experience menstrual pain? Yes ___ No ___	Before menses ___ During _____ (please specify which days) After ___
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What relieves the pain?	Stabbing ___ Cramping ___ Dull ___ Heavy ___ On/off ___
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Do you experience Pre-menstrual symptoms (PMS)? <small>Please check all that apply.</small>	
Breast tenderness ___ Cramps ___ Acne ___ Change in Bowel ___ Bloating ___ Headaches ___ Nausea ___ Moodiness ___	Fatigue ___ Night sweats ___ Sleep disturbances ___
Please list any other pre-menstrual symptoms	

Do you ovulate on your own? Yes ___ No ___ What Day? _____	Do you chart your cycle? (circle) BBT / Ovulation sticks / Saliva
Do you experience pain around ovulation? Yes ___ No ___	Do your breasts get tender around ovulation? Yes ___ No ___
Do you notice stretchy clear egg white slippery cervical mucous around ovulation? Yes ___ No ___	

How many times have you been pregnant? _____ How many times have you given birth? _____	
Ages of children _____	Sex of Children _____ Given names _____
Have you had any miscarriages? Yes ___ No ___	
If yes, how many, at how many weeks pregnant, and in what year(s)? _____	
How many times have you had a D&C preformed? _____	
How many abortions have you had? _____ In what year(s)? _____	
Were there any problems that occurred during these pregnancies? _____	

Have you ever been diagnosed with:	Unique shape of uterus? Yes ___ No ___
STD? Yes ___ No ___	Endometriosis? Yes ___ No ___
Pelvic inflammatory disease? Yes ___ No ___	PCOS (polycystic ovarian syndrome)? Yes ___ No ___
Uterine fibroids? Yes ___ No ___	Pelvic adhesions? Yes ___ No ___
Polyps? Yes ___ No ___	Prolapsed uterus? Yes ___ No ___

Do you have a single partner with whom you have been trying to conceive? Yes ___ No ___	
How long have you been married or living together?	What is your partner's name?
How long have you been trying to conceive?	

Have either you or your partner had a western medical diagnosis relating to fertility? Yes ___ No ___	
What was the diagnosis?	Who made the diagnosis?

Have you previously undergone assisted reproductive fertility treatments? (IUI, IVF, ICSI, superovulation, etc) Yes ___ No ___			
<u>Month / Year</u>	<u>Type of treatment</u>	<u>Clinic</u>	<u>Results</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you had any hormone lab tests performed? (i.e. day 3 / 21)			
FSH	___ Normal	___ High	___ Low
Estrogen, E2.....	___ Normal	___ High	___ Low
Progesterone.....	___ Normal	___ High	___ Low
Prolactin	___ Normal	___ High	___ Low
Thyroid	___ Normal	___ High	___ Low
Testosterone	___ Normal	___ High	___ Low
Other: _____	___ Normal	___ High	___ Low

How did you respond to the fertility treatments?
Poor ___ Good / average ___

Are you using donor sperm? Yes ___ No ___ **If Yes, why?** (circle) female partner / male partner has semen issues



LORNE BROWN, RAEGHAN SIEMENS, ALDA NGO, RYAN FUNK, EMILIE SALOMONS, CARY RENDEK
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PHONE: 604.678.8600 FAX: 604.678.8603 Website: www.acubalance.ca

Patient Information and Consent Form

Please read this information carefully, and ask your practitioner if there is anything that you do not understand.

While acupuncture, Chinese Medicine and other treatments provided by this clinic have proven to be highly effective in correcting conditions and maintaining overall well-being, practitioners are required to advise patients that there may be some risks. Although practitioners cannot anticipate all the possible risks and complications that may arise with each individual case, you should be aware that the following side effects can occur. If there are particular risks that apply in your case, your practitioner will discuss these with you.

What are the possible side effects of acupuncture?

- Drowsiness can occur in a small number of patients, and if affected, you are advised not to drive;
- Minor bleeding or bruising can occur from acupuncture;
- In less than 3% of patients, symptoms may become worse before they improve for 1-2 days following treatment. This is usually a good sign. Please advise your acupuncturist if worsening of symptoms continues for more than 2 days;
- Fainting can occur in certain patients, particularly at the first treatment;

What are the possible side effects of Chinese Medicine and other treatments provided at this clinic?

- Bruising (looks like a circular hickey) is a common side effect of cupping;
- The herbs and nutritional supplements from plant, animal and mineral sources that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses or inappropriate during pregnancy.

Is there anything your practitioner needs to know?

Apart from the usual medical details, it is important that you let your practitioner know:

- If you have ever experienced a fit, faint, or other odd detached sensations;
- If you have a pacemaker or any other electrical implants;
- If you are pregnant;
- If you have a bleeding disorder;
- If you are taking anti-coagulants (blood thinners) or any other medication;
- If you have damaged heart valves or have any other particular risk of infection.

Statement of Consent

I confirm that I have read and understood the above information, and I consent to having treatments and procedures from this clinic. I have read the possible risks of treatment outlined above, but do not expect the practitioner to be able to anticipate and explain all possible risks and complications of treatment. I also understand that I can refuse treatment at any time.

I wish to rely on my practitioner to exercise judgment during the course of treatment which, based upon the facts then known, is in my best interests. I understand the practitioner may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below I show that I have read this consent to treatment, have been told about the risks and benefits of treatments provided by this clinic, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and further conditions for which I seek treatment.

Privacy Policy

The information received and collected about our clients/patients from their visit to Acubalance is strictly private and confidential. It is used and viewed only by the healthcare professionals and staff employed by Acubalance, unless, in the best interest of the client/patient, a practitioner determines that there is a need to communicate with another person or healthcare professional outside of Acubalance (also, Acubalance will not give, share, sell, or transfer any personal information to a third party unless required by law). Under absolutely no circumstances would this communication happen without the signed consent of the client/patient. The client/patient information will be stored both in digital and hard copy format on Acubalance premises. On occasion, Acubalance may use client/patient information to conduct clinical studies to help us improve upon services provided.

Print name in full

(Print name of representative if represented by another)

Signature

(Signature of Representative)

Date



LORNE BROWN, RAEGHAN SIEMENS, ALDA NGO, RYAN FUNK, EMILIE SALOMONS, CARY RENDEK
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Patient Information Release Consent Form

I, _____ (please print name) give full consent so that _____(practitioner’s name) from Acubalance Wellness Centre may consult freely with Dr. _____ from Genesis Fertility Clinic regarding any of my medical treatments or relevant information. This could include the exchange of both verbal and written communications (including lab work).

The following is an authorization to provide Acubalance Wellness Centre with the following information (please check all that apply):

- All recent lab work results
 - All medical records
 - All semen test
- (to be filled out by your Acubalance practitioner)

I am nineteen years of age or older:

- Yes
- No

Client/Patient Signature: _____ Date: _____

Signature of parent of guardian (if applicable) _____

Thank-you for your prompt attention to this request. Please send any information by fax **604.678.8603**. If you have any questions, please feel free to contact us.