

Women's Fertility 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 /
Height /	Weight /	

Reason for Visit /	Have you had Acupuncture before? <span style="float: right;">Yes No</span>	
	Chinese herbal medicine? <span style="float: right;">Yes No</span>	

Family Physician name /	Family Physician phone /
Western Medical diagnosis (if applicable) /	

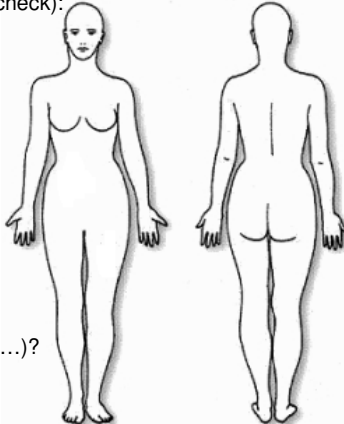
Other medical treatment received (circle) / Fertility clinic   Physiotherapy   Massage   Naturopathy   Chiropractic   Other:

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"/>	Spinal or head injury
<input type="checkbox"/>	Respiratory condition	<input type="checkbox"/>	Kidney disorder	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	HIV / AIDS	<input type="checkbox"/>	Sprain/Strain/Fracture	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	Headaches/migraines
<input type="checkbox"/>	Jaw pain	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Dizziness/fainting	<input type="checkbox"/>	Contagious illness
<input type="checkbox"/>	Skin condition	<input type="checkbox"/>	Digestive problems	<input type="checkbox"/>	Haemophiliac	<input type="checkbox"/>	Wear a pacemaker
<input type="checkbox"/>	Lung condition	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Possibility of Pregnancy	<input type="checkbox"/>	Upcoming Surgeries

On the figures below, please circle the areas of concern/pain ;

Sensations/pain characteristics (check):  
 Sharp \_\_\_ Burning \_\_\_  
 Moving \_\_\_ Tingling \_\_\_  
 Dull \_\_\_ Severe \_\_\_  
 Stabbing \_\_\_ Shooting \_\_\_  
 Throbbing \_\_\_ Numbness \_\_\_



What relieves the pain (ice, rest, activity, massage, heat...)?  
 \_\_\_\_\_  
 \_\_\_\_\_

What aggravates the pain (weather, heat, cold, rest, activity...)?  
 \_\_\_\_\_  
 \_\_\_\_\_

Please list any prescription medication or over the counter drugs currently taking:

1. _____	2. _____
3. _____	4. _____
5. _____	6. _____

Please list herbal medicine and other supplements currently taking:

1. _____	2. _____
3. _____	4. _____
5. _____	6. _____

Please list any allergies (food, drugs, environmental, etc.):

1. _____	2. _____
3. _____	4. _____

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).  
 \_\_\_\_\_  
 \_\_\_\_\_

Do you use the following? If so how often?   Cigarettes: \_\_\_\_\_ Alcohol: \_\_\_\_\_ Drugs: \_\_\_\_\_ Coffee: \_\_\_\_\_ Pop: \_\_\_\_\_

Do you participate in the following physical activities? If so, please indicate how often:			
Yoga:	Running:	Fitness Class:	Gym:
Biking:	Swimming:	Walking:	Other:

How did you hear about Acubalance? (Internet, Friend, Doctor, Fertility Clinic, Seminar, Magazine, TV, news) \_\_\_\_\_

<b>For each symptom below that you currently have, rate its severity from 1-5 (5 being worst). Leave blank if N / A.</b>		
<p><b>Gan</b></p> <p><input type="checkbox"/> Irritability / frustration / impatient</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Stress</p> <p><input type="checkbox"/> Emotional eating</p> <p><input type="checkbox"/> Unfulfilled desires</p> <p><input type="checkbox"/> Visual problems / floaters</p> <p><input type="checkbox"/> Blurred vision / poor night vision</p> <p><input type="checkbox"/> Red / Dry / Itchy eyes</p> <p><input type="checkbox"/> Headaches / Migraines</p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Feeling of lump in throat</p> <p><input type="checkbox"/> Muscle twitching / spasm</p> <p><input type="checkbox"/> Neck / shoulder tension</p> <p><input type="checkbox"/> Brittle nails</p> <p><input type="checkbox"/> Sighing</p> <p><input type="checkbox"/> Sensation or pain under rib cage</p> <p><input type="checkbox"/> PMS</p> <p><input type="checkbox"/> Genital itching / pain / rashes</p> <p><b>Xin</b></p> <p><input type="checkbox"/> Palpitations</p> <p><input type="checkbox"/> Chest pain / tightness</p> <p><input type="checkbox"/> Insomnia / Sleep problems</p> <p><input type="checkbox"/> Restless / easily agitated</p> <p><input type="checkbox"/> Vivid dreams</p> <p><input type="checkbox"/> Lack of joy in life</p> <p><input type="checkbox"/> Forgetful</p> <p><input type="checkbox"/> Aversion to heat</p> <p><input type="checkbox"/> Bitter taste in mouth</p> <p><input type="checkbox"/> Tongue / mouth ulcers / cankers</p>	<p><b>Shen</b></p> <p><input type="checkbox"/> Frequent urination</p> <p><input type="checkbox"/> Bladder infection</p> <p><input type="checkbox"/> Lack of Bladder control</p> <p><input type="checkbox"/> Wake to urinate</p> <p><input type="checkbox"/> Feel cold easily</p> <p><input type="checkbox"/> Cold hands / feet</p> <p><input type="checkbox"/> Night sweats / hot flushing</p> <p><input type="checkbox"/> Low sex drive</p> <p><input type="checkbox"/> High sex drive</p> <p><input type="checkbox"/> Loss of head hair</p> <p><input type="checkbox"/> Hearing problems</p> <p><input type="checkbox"/> Crave salty food</p> <p><input type="checkbox"/> Fear</p> <p><input type="checkbox"/> Poor long term memory</p> <p><input type="checkbox"/> Ankle swelling</p> <p><input type="checkbox"/> Tinnitus</p> <p><b>Fei</b></p> <p><input type="checkbox"/> Dry cough</p> <p><input type="checkbox"/> Cough with Phlegm</p> <p><input type="checkbox"/> Nasal discharge / drip</p> <p><input type="checkbox"/> Sinus infection / congestion</p> <p><input type="checkbox"/> Itchy / painful throat</p> <p><input type="checkbox"/> Dry mouth / throat / nose</p> <p><input type="checkbox"/> Skin rashes / hives</p> <p><input type="checkbox"/> Snoring</p> <p><input type="checkbox"/> Grief / sadness</p> <p><input type="checkbox"/> Shortness of breath</p> <p><input type="checkbox"/> Allergies / asthma</p> <p><input type="checkbox"/> Weak immune system</p> <p><input type="checkbox"/> Alternate fever / chills</p>	<p><b>Pi</b></p> <p><input type="checkbox"/> Heaviness in the head / body</p> <p><input type="checkbox"/> Fatigue / after eating</p> <p><input type="checkbox"/> Difficult getting up in morning</p> <p><input type="checkbox"/> Water retention</p> <p><input type="checkbox"/> Muscular tired / weak</p> <p><input type="checkbox"/> Bruise easily</p> <p><input type="checkbox"/> Unusual bleeding (stool, nose, etc)</p> <p><input type="checkbox"/> Bad breath</p> <p><input type="checkbox"/> Poor appetite</p> <p><input type="checkbox"/> Increased appetite</p> <p><input type="checkbox"/> Crave sweets</p> <p><input type="checkbox"/> Poor digestion</p> <p><input type="checkbox"/> Nausea / vomiting</p> <p><input type="checkbox"/> Bloating / gas</p> <p><input type="checkbox"/> Hemorrhoids</p> <p><input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Loose stool</p> <p><input type="checkbox"/> Alternate constipation / loose</p> <p><input type="checkbox"/> Abdominal pain</p> <p><input type="checkbox"/> Intestinal pain / cramping</p> <p><input type="checkbox"/> Heartburn</p> <p><input type="checkbox"/> Pensive / over-thinking</p> <p><input type="checkbox"/> Overweight</p> <p><input type="checkbox"/> Foggy mind</p> <p><input type="checkbox"/> Yeast infection</p> <p><input type="checkbox"/> Aversion to cold</p> <p><input type="checkbox"/> Cold nose</p> <p><input type="checkbox"/> Increased Thirst</p> <p><input type="checkbox"/> Prefer Warm / Cold drinks</p> <p><input type="checkbox"/> Sweat easily</p>

Besides fertility, list your main health concerns in order of importance to you:	1.	2.
	3.	4.

On a scale of 1-10, how would you rate your daily energy level (10 being best)?

What is your occupation? Do you enjoy your work? How many hours per week do you work? Is it stressful? What are your duties?

Are your bowel movements regular? How many times per day/week? Are they formed, loose, constipated, or do they alternate from loose to difficult to pass?

Do you experience urinary frequency, urgency, burning, dribbling, retention? What colour/shade of yellow is it? Do you have a history of urinary tract infections?

How many glasses of water do you drink in a day? How Many times in your life have you taken Antibiotics (approx. #)? How many times have you taken oral steroids?

Please describe in general what you eat, and what do you crave? (sweet, spicy, salty, organic, wheat, dairy, meat, veggies, fruit, pasta, sandwiches, soups, etc.)

Do you have trouble falling asleep? Are you a light sleeper? How many hours per night? Do you have vivid dreams? If so, what are they about? Wake and have difficulty falling back to sleep?

If you were asked to describe yourself from an emotional standpoint, what would you say (i.e. irritable, worrier, anxious, sad, impatient, stressed, etc.)?

In the spaces below, please provide us with a thorough answer to each question so that we can understand your goals and dreams.

Why do you want to have a child?

What makes a good parent?

How do you nurture your self, your relationship?

How would you describe your relationship?

What brings you joy?

What are you grateful for?

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 any Spotting?:** Yes \_\_\_ No \_\_\_      **For how many days?** \_\_\_\_\_

Do you experience menstrual pain? Yes ___ No ___	Before menses ___ During _____ (please specify which days) After ___
What relieves the pain?	Stabbing ___ Cramping ___ Dull ___ Heavy ___ On/off ___

**Do you experience Pre-menstrual symptoms (PMS)?** Please check all that apply.

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? \_\_\_\_\_

<b>Have you ever been diagnosed with:</b> STD? ..... Yes ___ No ___ Pelvic inflammatory disease? ..... Yes ___ No ___ Uterine fibroids? ..... Yes ___ No ___ Polyps? ..... Yes ___ No ___ Pelvic adhesions? ..... Yes ___ No ___ Prolapsed uterus? ..... Yes ___ No ___ Unique shape of uterus? ..... Yes ___ No ___ Endometriosis? ..... Yes ___ No ___ PCOS (polycystic ovarian syndrome)? ..... Yes ___ No ___	Date of last pap smear: _____ / _____ / _____ (dd/mm/yyyy) Have you ever had an abnormal pap smear? Yes ___ No ___ Have you ever had a cervical biopsy or operation? Yes ___ No ___ Do you get yeast infections regularly? Yes ___ No ___ Do you get bladder infections regularly? Yes ___ No ___ If answered yes, list STD's: _____
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**Do you experience vaginal discharge?** Yes \_\_\_ No \_\_\_  
**If yes, what colour?**  
 White \_\_\_ Yellow \_\_\_ Green \_\_\_ Pinkish \_\_\_ Red \_\_\_  
**If yes, what consistency?**  
 Watery / thin \_\_\_ Thick \_\_\_ Sticky \_\_\_  
**If yes, does it have foul odour?** Yes \_\_\_ No \_\_\_

**Have you taken oral contraceptives?** Yes \_\_\_ No \_\_\_  
**If yes, for how long?** \_\_\_\_\_  
**When did you stop?** \_\_\_\_\_  
**Have you ever had an IUD?** Yes \_\_\_ No \_\_\_  
**Have you ever taken Depo-Provera?** Yes \_\_\_ No \_\_\_

What is your partner's name?	How long have you been married or living together?
How long have you been trying to conceive?	Are they supportive of your wishes to conceive? Yes ___ No ___
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 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

**Have you taken medication to help you ovulate?**  
Yes \_\_\_ No \_\_\_  
If yes, what kind? \_\_\_\_\_  
For how many cycles? \_\_\_\_\_

**Have you had your uterine/fallopian tubes evaluated medically (HSG)?** Yes \_\_\_ No \_\_\_  
What were the results?  
\_\_\_\_\_

Have you had any tubal operations? Yes \_\_\_ No \_\_\_

**Have you ever undergone assisted reproductive treatments?** (IUI, IVF, ICSI, superovulation, etc) Yes \_\_\_ No \_\_\_

<u>Month / Year</u>	<u>Type of treatment</u>	<u>Clinic</u>	<u>Results</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**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/ single

How is your sexual desire (mental interest)?	Low ___	Normal ___	High ___
How is your sexual arousal (physically / orgasm)?	Low ___	Normal ___	High ___
Do you use vaginal lubricants?	Yes ___	No ___	
Have you been exposed or received chemotherapy or radiation?	Yes ___	No ___	
Do you have excessive facial / body hair?	Yes ___	No ___	
Do you have excessive oily skin?	Yes ___	No ___	

**On your journey toward parenthood, what expectations do you have of Acubalance Wellness Centre. Please provide the wellness goals you wish to obtain here:**

**Please consider letting us know what you need most from during our time together (check as many as you wish):**

- |  |  |  |
|--|--|--|
| <p>___ <b>Perspective</b></p> <ul style="list-style-type: none"> <li>• Provide a fresh or different way at looking at a situation</li> </ul> <p>___ <b>Validation</b></p> <ul style="list-style-type: none"> <li>• Provide encouragement and acknowledgement</li> </ul> <p>___ <b>Message</b></p> <ul style="list-style-type: none"> <li>• Share fitting knowledge, opinion, or wisdom</li> </ul> <p>___ <b>Advice</b></p> <ul style="list-style-type: none"> <li>• Provide advice via recommendations and suggestions</li> </ul> <p>___ <b>Feedback</b></p> <ul style="list-style-type: none"> <li>• Offer feedback, observation, insight, idea, and opinion</li> </ul> | <p>___ <b>Energy</b></p> <ul style="list-style-type: none"> <li>• Provide positive energy and support</li> </ul> <p>___ <b>Solutions</b></p> <ul style="list-style-type: none"> <li>• Share solutions to problems or issues</li> </ul> <p>___ <b>Plan</b></p> <ul style="list-style-type: none"> <li>• Co-develop a plan of action with you</li> </ul> <p>___ <b>Challenge</b></p> <ul style="list-style-type: none"> <li>• Provide a challenge to you to stretch or make a change</li> </ul> <p>___ <b>Tough love</b></p> <ul style="list-style-type: none"> <li>• When necessary, have the conversations you may least want to have</li> </ul> | <p>___ <b>Structure</b></p> <ul style="list-style-type: none"> <li>• Provide support and a check-in structure for you</li> </ul> <p>___ <b>Resource</b></p> <ul style="list-style-type: none"> <li>• Suggest/refer you to experts, books, tools, assessments</li> </ul> <p>___ <b>Caring</b></p> <ul style="list-style-type: none"> <li>• Provide listening, patience, safety, and love</li> </ul> <p>___ <b>Removed</b></p> <ul style="list-style-type: none"> <li>• You may just want to come and relax, nothing more</li> </ul> |
|--|--|--|

## 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;

### 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;

### 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.
- 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.

### Appointment Policy

Welcome to Acubalance Wellness Centre. We are delighted to have you as a patient and look forward to providing you with the highest quality care. In order to optimize your relationship with us, please take a minute to read our appointment policy.

Many of our clients are pleased to find out that we are usually on time. This is because **a treatment room has been reserved for you**, whereas most medical offices overbook by appointing several patients at the same time. That kind of scheduling provides the practitioner with a steady flow of patients but does not respect the patient's time.

Occasionally, there is a problem with patients who are not used to staying on schedule themselves. With that in mind, if you are going to be more than 15 minutes late, please call to confirm availability. A 24 hour notice for cancelled or rescheduled appointments is necessary in order to avoid the cancellation fee. This allows us time to schedule another patient that would also benefit from treatment. This appointment policy allows us to develop a mutual consideration and respect for our time and yours.

\_\_\_\_\_  
Print name in full

\_\_\_\_\_  
(Print name of representative if represented by another)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
(Signature of Representative)

\_\_\_\_\_  
Date

## Patient Information Release Request Form

I, \_\_\_\_\_ (please print name) give full consent so that Acubalance Wellness Centre may consult freely with other physicians and healthcare professionals (of which whose care I am under) regarding any of my medical treatments or relevant information. This could include the exchange of both verbal and written communications (including lab work).

*(to be filled out by your Acubalance practitioner)*

The following is an authorization to provide Acubalance Wellness Centre with the following information:

- All recent lab work results
- All medical records
- All semen tests
- Other: \_\_\_\_\_

Medical Services Plan (MSP) #:

I am nineteen years of age or older:

- Yes
- No

Client/Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of parent or guardian (if applicable): \_\_\_\_\_

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

Acubalance Wellness Centre Ltd.