

LORNE BROWN, ALDA NGO, RYAN FUNK, EMILIE SALOMONS, BRONWYN MELVILLE, CHRISTINA CECCONI, KALI MACISAAC,
 SUITE 250 - 828 WEST 8TH AVE., VANCOUVER BC, V5Z 1E2
 PHONE: 604-678-8600 FAX: 604-678-8603 Website: www.acubalance.ca

Men's 15-min Q&A

Date:

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

Reason for Visit /	Have you had Acupuncture before?	Yes	No
	Chinese herbal medicine?	Yes	No

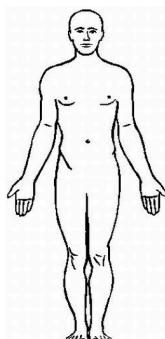
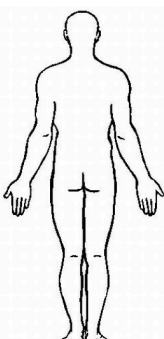
Family Physician name /	Family Physician phone /
Western Medical diagnosis (if applicable) /	

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 condition	<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"/>		<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) _____

For each symptom below that you currently have, rate its severity from 1-5 (5 being worst). Leave blank if N / A.

<p>Gan</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"/> Genital itching / pain / rashes</p> <p>Xin</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>Shen</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>Fei</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>Pi</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>
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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)?

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.)?

acubalance

WELLNESS CENTRE

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Name of spouse or partner: _____

How long have you and your partner been trying to conceive? _____

Are you currently undergoing assisted reproductive treatments (IUI, IVF, ICSI, superovulation, etc.)? Yes No

If yes, at what fertility clinic? _____

How is your sexual energy/libido?	<input type="checkbox"/> Below normal	<input type="checkbox"/> Normal	
Have you had a recent physical exam?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you or did you have an undescended testicle?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Have you ever been diagnosed with a varicocele?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Have you ever had any urologic surgeries?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Have you experienced erectile dysfunction?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Have you experienced difficulty ejaculating?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Have you been exposed to any environmental toxins or hormones?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Have you experienced any penile discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you regularly experience nocturnal emission?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you have high cholesterol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Have you had a high fever in the past 6 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you currently have any prostate conditions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you have or have you ever had urinary infections or STDs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Have you ever taken testosterone supplements/drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Have you recently had your testosterone levels checked?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Have you been diagnosed with small or soft testes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Have you been checked for a blockage of your reproductive tract?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Have you had any fertility testing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If yes, what was your sperm count?	<input type="checkbox"/> Low	<input type="checkbox"/> Normal	Count: _____
What was the sperm motility?	<input type="checkbox"/> Low	<input type="checkbox"/> Normal	Notes: _____
What was the sperm morphology?	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Normal	Notes: _____

Other comments: