

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

Women's 15-min Q&A

Date:

Last name /		First name /		Circle: Miss 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 /		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:

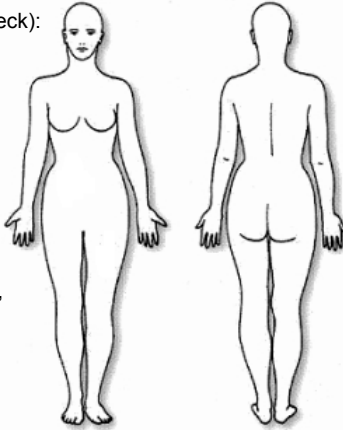
<input type="checkbox"/>	Heart conditions	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	Low blood pressure
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Deep vein thrombosis	<input type="checkbox"/>	Neurological condition	<input type="checkbox"/>	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"/>	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) _____

If referred by current patient, we would like to thank your friend for the referral

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 / impatience</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>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>

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 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? Do you 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.)?

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 ___
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 mucus 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: 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 STDs: _____
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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 ___

Have you had any hormone testing done? (e.g., Day 3, Day 21)			
FSH	<input type="checkbox"/> Low	<input type="checkbox"/> Normal	<input type="checkbox"/> High
Estrogen (E2)	<input type="checkbox"/> Low	<input type="checkbox"/> Normal	<input type="checkbox"/> High
Progesterone	<input type="checkbox"/> Low	<input type="checkbox"/> Normal	<input type="checkbox"/> High
Prolactin	<input type="checkbox"/> Low	<input type="checkbox"/> Normal	<input type="checkbox"/> High
Thyroid (TSH)	<input type="checkbox"/> Low	<input type="checkbox"/> Normal	<input type="checkbox"/> High
Testosterone	<input type="checkbox"/> Low	<input type="checkbox"/> Normal	<input type="checkbox"/> High
Other: _____	<input type="checkbox"/> Low	<input type="checkbox"/> Normal	<input type="checkbox"/> High

Do you currently have a partner? Yes No
 If yes, what is your partner's name? _____ Age? _____
 Are you married or living together? _____ For how long? _____
 Is your partner supportive of your wishes to conceive? _____

How long have you been trying to conceive? _____

Do you have a family history of infertility (mother, father, grandparents, aunt, uncle, siblings)? _____
 If yes, which family members? _____ Diagnosis? _____

Have you had a Western medical diagnosis relating to fertility? Yes No
 If yes, what was the diagnosis? _____ Who made the diagnosis? _____

Has your partner (if applicable) had a Western medical diagnosis relating to fertility? Yes No
 If yes, what was the diagnosis? _____ Who made the diagnosis? _____

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

Month/Year	Type of treatment	Clinic	Results

What was your medical response to the fertility treatments? Poor Average Good

Are you using donor sperm? Yes No
 If yes, why? (no partner, female partner, male partner has semen issues, etc.) _____

Are you using donor eggs or embryos? Yes No

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