acubalance
WELLNESS CENTRE

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

On-Site Olive Transfer Form

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 /

How did you hear about Acubalance? Internet, Friend

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__	Unique shape of uterus?	Yes__ No__
Pelvic inflammatory disease?	Yes__ No__	Endometriosis?	Yes__ No__
Uterine fibroids?	Yes__ No__	PCOS (polycystic ovarian syndrome)?	Yes__ No__
Polyps?	Yes__ No__	Pelvic adhesions?	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?

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Have you previously undergone assisted reproductive fertility treatments? (IUI, IVF, ICSI, superovulation, etc) Yes ___ No ___

Month / Year	Type of treatment	Clinic	Results

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

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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

Please print, complete, and fax in forms before your initial appointment. Thank you.