# acubalance
wellness centre

LORNE BROWN, SPENCE PENTLAND, RAEGHAN SIEMENS, ALDA NGO, TREVOR ERIKSON, RYAN FUNK, EMILIE SALOMONS
SUITE 250 - 828 WEST 8TH AVE,. VANCOUVER BC, V5Z 1E2 & SUITE 104 - 8843 204 STREET, LANGLEY BC, V1M 1E6
PHONE: 604.678.8600 FAX: 604.678.8603 (Vancouver) 604.881.1196 (Langley) Website: www.acubalance.ca

Pregnancy Forms

3Date:

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? Yes No
Chinese herbal medicine? Yes No

Family Physician name / Family Physician phone /

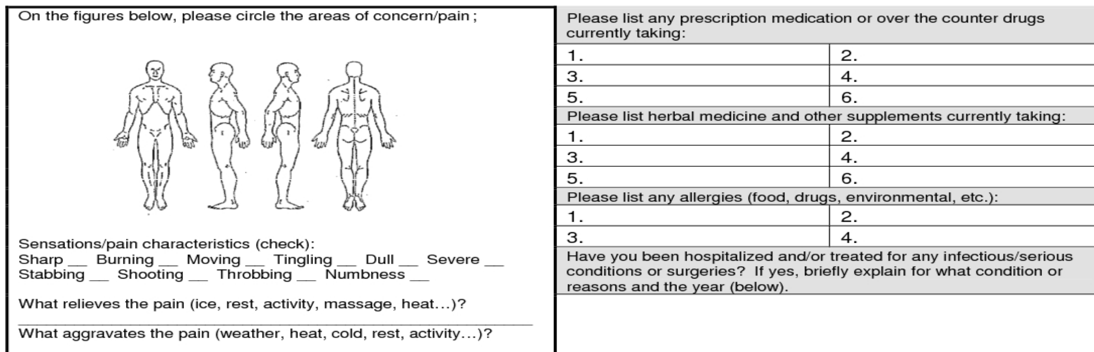
Western Medical diagnosis (if applicable) /

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:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Heart conditions | | Stroke | | High blood pressure | | Low blood pressure |
| | Diabetes | | Deep vein thrombosis | | Neurological | | Spinal or head injury |
| | Respiratory condition | | Kidney disorder | | Cancer | | Hepatitis |
| | HIV / AIDS | | Sprain/Strain/Fracture | | Osteoporosis | | Headaches/migraines |
| | Jaw pain | | Arthritis | | Dizziness/fainting | | Contagious illness |
| | Skin condition | | Digestive problems | | Haemophiliac | | Wear a pacemaker |
| | Lung condition | | Epilepsy | | Possibility of Pregnancy | | 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) ___________________________

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