

acubalance
wellness centre

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Pregnancy 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 / _____			

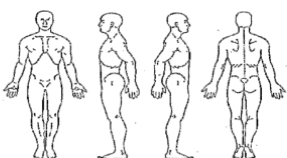
Reason for Visit / _____	Have you had Acupuncture before? Yes No
	Chinese herbal medicine? Yes No

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	<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"/> Haemophilic	<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

<p>On the figures below, please circle the areas of concern/pain;</p> <div style="text-align: center;">  </div> <p>Sensations/pain characteristics (check): Sharp ___ Burning ___ Moving ___ Tingling ___ Dull ___ Severe ___ Stabbing ___ Shooting ___ Throbbing ___ Numbness ___</p> <p>What relieves the pain (ice, rest, activity, massage, heat...)? _____</p> <p>What aggravates the pain (weather, heat, cold, rest, activity...)? _____</p>	<p>Please list any prescription medication or over the counter drugs currently taking:</p> <table style="width: 100%;"> <tr><td>1. _____</td><td>2. _____</td></tr> <tr><td>3. _____</td><td>4. _____</td></tr> <tr><td>5. _____</td><td>6. _____</td></tr> </table> <p>Please list herbal medicine and other supplements currently taking:</p> <table style="width: 100%;"> <tr><td>1. _____</td><td>2. _____</td></tr> <tr><td>3. _____</td><td>4. _____</td></tr> <tr><td>5. _____</td><td>6. _____</td></tr> </table> <p>Please list any allergies (food, drugs, environmental, etc.):</p> <table style="width: 100%;"> <tr><td>1. _____</td><td>2. _____</td></tr> <tr><td>3. _____</td><td>4. _____</td></tr> </table> <p>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):</p> <p>_____</p>	1. _____	2. _____	3. _____	4. _____	5. _____	6. _____	1. _____	2. _____	3. _____	4. _____	5. _____	6. _____	1. _____	2. _____	3. _____	4. _____
1. _____	2. _____																
3. _____	4. _____																
5. _____	6. _____																
1. _____	2. _____																
3. _____	4. _____																
5. _____	6. _____																
1. _____	2. _____																
3. _____	4. _____																

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.