High 5 Acupuncture

1150 Maxwell Ave. Suite 100, Boulder, CO 80304

217-979-9822

Welcome to High 5 Acupuncture! I'm so thrilled for the opportunity to work with you. Below you will find some details about our work together. If you have any questions after reading this over, please don't hesitate to give me a call. Also, please fill out the attached paperwork and either bring it with you to your first session or email it to high5acupuncture@gmail.com.

Your first visit is a time for me to understand your reasons for seeking acupuncture treatment and to assess your current condition. We will begin with an in-depth interview covering your medical history and the events and experiences that contribute to your reasons for coming, including personal history. The first visit will also include a physical examination, energy assessment, and an acupuncture session. Please do not wear make-up or any scented products to this appointment. Plan 1.5-2.5 hours for this appointment.

Each subsequent session will begin with a time for you to communicate your current experiences and progress. I will check your meridian pulses to assess your energy flow that day. Each treatment will consist of 4 to 8 points that support our overall treatment goals, typically using moxabustion and needles. The changes that you feel during a treatment can be subtle or profound. These sessions will take approximately 45 mins - 1 hour.

Frequency of Treatment: Our goal is to build up your core energy and make sure that energy is flowing well and in the right proportion. Each treatment builds on the previous one. I recommend that new clients schedule weekly treatments for the first 4-8 weeks. Once your energy is balanced and holding from one week to the next, sessions can then be extended to every other week and gradually further apart until you are coming only monthly or seasonally for maintenance. Depending on your specific situation, it may be best to see you several times a week in the beginning to get a jump start on your healing. Please bring your calendar to the first treatment so that we can schedule your first series of appointments. If receiving treatments specifically for pain, I will need to see you 2-3 times a week for 2 weeks and will determine treatment frequency after that depending on how the pain responds to treatment.

Day of Treatment: It is best to avoid excesses on the day of treatment in order to get the maximum benefit. It is best not to eat a heavy meal just before or after a treatment, or arrive too hungry. If possible, avoid caffeine, alcohol, very hot or cold bathing, extreme exercise, etc. You may want some time to relax afterwards or to have an early bedtime that night.

Weekly Suggestions: Although each person responds at their own rate, the rate of progress can be affected by how long you've had your condition and also by certain lifestyle choices that might hinder your progress. Part of our work together will be identifying the areas that need attention from you in order to improve your health. These areas may include nutrition, avoiding allergens, movement/exercise, increase in water intake, etc. Suggestions for change will be discussed and agreed upon with you, and may help us to identify areas that need further support.

Acupuncture has been shown to be very effective for a wide range of problems and I hope that we will have great success together in bringing you into a better state of health. The healing process happens differently for each individual. There are no guarantees with acupuncture or with any other healing method. It is my experience that within the first three treatments we will both have a sense of whether you are getting a good response and if any adjustments need to be made to your frequency of treatment or lifestyle. Often the first improvements noticed are in your general state of health or energy.

Details: Acupuncture involves the use of needles inserted just below the surface of the skin. The needles are very thin, barely more than the width of a human hair. When the needle is inserted a very slight prick may be felt; when the needle contacts the energy, the sensation may vary from a pull to a buzz or small ache. These sensations are very brief. The needles are made of surgical stainless steel, are pre-sterilized and disposed of after each use. I also often use Moxa, an herb (Atemesia Vulgaris) used to warm acupuncture points by placing a small lit cone on the skin to be removed when you feel warmth. In addition I may use acupressure or zero balancing to enhance your acupuncture treatments. "Zero Balancing is a hands-on body/mind system of therapy designed to enhance health by balancing body energy with body structure." - Fritz Smith, MD and founder of ZB.

Medications and Doctors: If you are currently taking any medication, continue taking it exactly as you have been, per your prescriptions. Acupuncture works with the other care that you may be receiving. If and when it is appropriate, you may discuss reducing your medication with your physician and follow their guidance in doing so. If you have a medical emergency, please contact your personal physician or an emergency care facility. After receiving emergency medical attention, please let me know how you are doing and the details of your medical treatment so I can provide you with the most appropriate treatment at our next appointment.

Payment Policy: I accept cash, check and all major credit cards, including HSA and Flex Spending cards, although I prefer cash or check. I expect payment at the time service is rendered. I have a 24 hour cancellation policy. Please let me know if you need to change your appointment at least 24 hours in advance. Unless you are in an emergency situation, you will be asked to pay for missed appointments in which you do not give 24 hrs notice.

Initial intake (which includes your first acupuncture treatment) = $150

Each subsequent treatment = $90

Contact: At times during our work together I may ask you to check in with me or you may have a response that you would like to talk with me about. Please feel free to call me at 217-979-9822 or email high5acupuncture@gmail.com. If I am not available, please leave a message and I will respond within 24 hrs. For rearranging appointment times please use the scheduling website https://high5acupuncture.as.me/or text message. If you are running late to an appointment, a text message is helpful.

Directions: My office is located at *1150 Maxwell Ave, Suite 100*. (Southwest corner of Broadway & Maxwell in Boulder). There is a parking lot right outside the building. Come on into the suite and have a seat in the waiting area. Please call or text if you have any problems finding it.

> High Five Acupuncture treatments can be a powerful, transformative and integral part of your healing journey. I look forward to working together to relieve the symptoms you may be experiencing, while providing a platform for rediscovering your soul's longing and enabling you to live the life of your dreams.
>
> Sincerely, *Kelly*

ACUPUNCTURE DISCLOSURE & CONSENT FORM

Kelly Kessen, M.Ac, Dipl.Ac., L.Ac.

Education and Background:

- Licensed Acupuncturist in the State of Colorado (LAc)
- Masters in Acupuncture in Classical Five Element Acupuncture - Institute of Taoist Education and Acupuncture (MAc) – 2013
- National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) Diplomate in Acupuncture (Dipl Ac) – 2013

- Council of Colleges of Acupuncture and Oriental Medicine Clean Needle Technique Course – 2011
- B.A. in Science, Arizona State University – 2003

The acupuncturist practicing is compliant with any rules and regulations promulgated by the Colorado Department of Health related to the proper cleaning and sterilization of needles used in the practice of acupuncture and the sanitation of acupuncture offices. Only single-use disposable needles are used and they are disposed of in a manner consistent with OSHA and Colorado State regulations.

You (the patient) are entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known. You (the patient) are entitled, and encouraged, to seek a second opinion from another health care professional. You (the patient) are entitled to terminate therapy at any time.

In forming a professional relationship, that which exists between practitioner and patient, sexual intimacy is never appropriate and should be reported to the Director of the Division of Professions and Occupations in the Department of Regulatory Agencies.

The practice of acupuncture is regulated by the Dept. of Regulatory agencies. Any concerns or complaints can be directed to: Director of Professions and Occupations, Acupuncturist Licensure, 1560 Broadway, Ste 1350, Denver, CO 80202-5140, 303-894-7800.

The recommendation and application of adjunctive therapies and herbs is based on the training and experience defined by traditional oriental medicine concepts.

Fee schedule: Initial office visit with first treatment $150.00 Each subsequent treatment $90.00

24 hours notice is required for cancellation of a scheduled appointment, or the patient will be billed for the missed appointment. You will not be charged for an appointment missed due to an emergency. Unless prior arrangements have been made, all clients are asked to pay in full at time of visit. Please let me know if you would like a receipt to send to your insurance carrier for reimbursement. There is a fee of $35 for returned checks.

Acupuncture is performed by the insertion of specialized needles through the skin, and/or by applying heat via moxibustion at certain points on the body. I understand that treatments performed are not intended to replace medical attention. I have been informed that this is a generally safe method of treatment but may have side effects such as minor bruising or tingling near the insertion point, or occasional dizziness. Other potential risks include: infection (all needles are sterile and disposable so this risk is extremely small), puncture of nerves, arteries or veins, puncture of vital organs (this mostly involves the lungs, if shortness of breath is experienced it needs immediate medical care.) I will notify the acupuncturist if I am or am trying to become pregnant, am on blood thinners, have a metal or other prosthetic body part, have high/low blood pressure, or a history of fainting or seizures.

I understand the risks and benefits involved. My participation is voluntary. I understand that no guarantee is made concerning the outcome of acupuncture treatment. I further understand and agree to hold harmless, to indemnify and protect against court action the individual therapist as well as the management and owners of this clinic, in the event of accidental injury on these premises.

I have read the above Disclosure and Consent Form and I have discussed the full nature and purpose of treatment with my acupuncturist. I certify that I have had all of my questions regarding the use of acupuncture and adjunct therapies answered to my satisfaction. I certify that I have read and understand this document.

I hereby voluntarily consent to be treated with acupuncture, moxibustion and zero balancing by Kelly Kessen, Dipl. Ac, L.Ac. By signing below, I agree to all terms and conditions stipulated by this document. I intend for this form to cover the entire course of treatment for my condition and for any future condition(s) for which I seek treatment.

_____	_____	_____
Patient Name (Print)	Patient's Signature	Date
_____	_____	_____
Parent/Guardian's Name (Print)	Parent/Guardian's Signature	Date

Client Intake Form

Name: _____ Today's Date:_____

Address: _____ Birth Date: _____ Age: _____

City: _____ State: _____ ZIP: _____ Gender Identity:_____

Primary Phone #: _____ Occupation: _____

Can I text this #? Yes/No
Can I leave a voice message? Yes/No

Are you a student? _____
Primary Physician: _____

E-mail: _____ Phone #: _____
Emergency Contact Name: _____ Are you married? Yes/No
Phone #: _____ Spouse or Partner's Name: _____
Relationship: _____ Do you have children? Yes/No
How did you hear about High 5? _____ If yes, their ages? _____

General Health and Nutrition Questions

What is your main concern(s) or symptom(s) you would like help with?

_____
_____
_____
_____
_____

When did it begin (mm/dd/yyyy) _____

Do you have any idea what may have caused it?

_____
_____

To what extent does it interfere with your daily life? (work, exercise, sleep, relationships, etc)

_____
_____

Does it cause you to miss work? Yes/no If yes, how often?

_____

Have you been given a diagnosis? Yes/no If yes, what and from whom?

_____
_____

What other treatments have you tried? Did they help? Are you still receiving them?

_____
_____
_____

Is there anything that improves or worsens your concern/symptom?

_____

_____

_____

Do you have any other concerns or symptoms?

_____

_____

_____

Medications/Supplements: Please list all medications, vitamins, herbs, supplements you are currently taking (including over-the-counter medications) and what you are taking them for:

Medication/Supplement:	Reason for taking and how long you've been taking:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Are you currently taking an anticoagulant medication (blood thinner)? Yes/no

Past Medical History:

Please list any surgeries or hospitalizations (including the dates):

_____

_____

_____

Which of the following pertains to you? *(please note dates and specifics)*

▫ Asthma	▫ Emphysema	▫ High Blood Pressure	▫ Psychological Concerns
▫ Allergies (seasonal, environmental, food)	▫ Epilepsy	▫ Heart Disease	▫ Rheumatic Fever
▫ Appendicitis	▫ Gastrointestinal	▫ Lyme Disease	▫ Seizures
▫ Alcoholism/Addiction	▫ Goiter	▫ Measles	▫ Sinusitis
▫ Anxiety/Depression	▫ Gout	▫ Multiple Sclerosis	▫ Sleep Disorder
▫ Cancer	▫ Gynecological	▫ Mumps	▫ Stroke
▫ Cardiovascular	▫ Headaches	▫ Musculoskeletal	▫ Thyroid Condition
▫ Chicken Pox	▫ Hepatitis	▫ Pacemaker	▫ Tuberculosis
▫ Diabetes	▫ Herpes	▫ Pneumonia	▫ Typhoid Fever
▫ Dizziness	▫ HIV/AIDS	▫ Polio	▫ Venereal Disease

Have you experienced any other trauma or injuries?

_____

_____

_____

_____

Nutrition:

How do you feel about your current eating habits?

_____

_____

Which of these describe your current eating habits? (choose all that apply)

▫ Average Diet ▫ Low Calorie ▫ Low fat/cholesterol ▫ No red meat ▫ Vegetarian ▫ Vegan ▫ Kosher

▫ Diabetic-specific diet ▫ Gluten-free ▫ Dairy-free ▫ Other _____

Do you have any known food allergies or sensitivities?

_____

_____

_____

_____

Please record what you eat for three days (or for the past 3 days):

	Day 1	Day 2	Day 3
Breakfast (include coffee/tea)			
Lunch			
Dinner			
Snacks (include times of day)			
Fluids (water, coffee, soda, tea, fruit juice, alcohol)			

How many servings a day do you typically consume the following:

Meat_____ Fish _____ Dairy _____ Grains _____ Vegetables _____ Fruit _____

How often do you consume the following: (several times a day, daily, weekly, occasionally)

Sweets/Sugar _____ Chocolate _____ Junk Food _____ Processed/Canned Food _____

Soda _____ Coffee _____

What are the foods you crave most?

_____

Have you ever struggled with your eating habits?

_____

How much water do you drink a day (in ounces)? _____ Is it purified/bottled/tap?_____

Do you smoke cigarettes or chew tobacco? Yes/no If yes, how much? _____

How often do you consume alcohol? _____ What type? _____

How often do you use recreational drugs? _____ What type? _____

Sleep:

How would you describe your sleep?

_____

How many hours do you get a night? _____ Do you wake up feeling rested? _____

What time do you go to bed? _____ What time do you wake up? _____ Do you use an alarm? _____

Do you get tired during the day? _____ Do you take naps? _____

Digestion/Urination:

How often do your bowels move? _____

How often do you experience the following?

▫ Constipation_____ ▫ Diarrhea/loose stools _____ ▫ Bloating _____ ▫ Gas _____

▫ Stomachache _____ ▫ Heartburn/Indigestion _____ ▫ Nausea _____ ▫ Other _____

How often do you urinate? _____ Do you ever have any pain, discomfort, or urgency? _____

Complete the following questions which apply to you:

Date of your last menses? _____ Date of your last pap exam? _____

How would you describe your menstrual cycle?

_____

_____

Is your cycle consistent/regular intervals? Yes/No If no, please explain

_____

Please describe any pain or other symptoms that you experience during your cycle. (ie tender breasts, nausea, heavy flow, endometriosis, fibroids, clotting)

_____

_____

_____

Are you pregnant? Yes/No # of pregnancies _____ # of births _____ # of children _____

Do you currently use birth control? If so what type _____ Age of menopause (if applicable) _____

Do you do self breast exams? Yes/No

Do you have a history with prostate problems, erectile dysfunction or fertility issues? If yes please explain:

_____

_____

Date of last physical exam? _____

Other:

Please note any pertinent family medical history (cancer, heart disease, mental illness, other)?

_____

_____

_____

How is your general energy?

_____

_____

What kind of exercise or movement do you enjoy? _____

How often do you do these activities? _____

Does the amount of exercise you get affect you in any way? _____

Please use the space below to share anything else about yourself you would like me to know about, I look forward to working with you:

I verify that this information is true and complete.

Signature _____ Date _____