Welcome

Instructions for Acupuncture and Thai Bodywork:

1. What to wear: For acupuncture, bring shorts or wear loose-fitting clothes.
   For Thai Bodywork, bring or wear loose or stretchy long pants and a comfortable shirt (long or short sleeved).

2. Try to arrive a few minutes early to ensure a relaxed visit. If you arrive very late your appointment will be fit into the available time schedule, in order not to inconvenience other clients.

3. Please eat a light meal before your treatment. A lack of food or sleep has on rare occasions been known to result in a brief condition of fatigue, nausea and possibly fainting.
   Avoid alcoholic beverages for the day and night following treatment.

4. If you have a pacemaker, varicose veins or a bleeding disorder please notify us prior to any treatment.

Financial Policy:

Acupuncture is $85 for the initial session and $75 for follow-up appointments.
The initial acupuncture session takes about 1 hour 45 minutes. Follow-ups take one hour.
For adjunct modalities that require added time such as moxa, cupping, local Tui Na/Asian bodywork, “double” treatments (i.e. front and back), etc, addition charges ranging from $5-$35 may be applicable. Clients will not be charged without consent.

Thai Bodywork is $100 for 90 minutes and $130 for 2 hours.

Zero Balancing is $75 per session which takes 45-60 minutes.

Payment in full is due at the time of service – cash, check or credit/debit card.

Cancellation Policy:

Please call *at least* 24 hours in advance if you need to cancel or reschedule an appointment in order to allow adequate time for other clients to be scheduled. I charge full price for appointments missed or cancelled without providing 24-hour notice, except in the case of an emergency. Thank you for respecting my time.

Public Safety Policies:

In order to provide for maximum safety, I use sterile disposable needles on all clients.

Location:

My office is in the Omnium Gatherum building at 65 Pearl Street in Burlington.
It is located on the corner of Pearl and Pine Streets, directly across the street from Bove’s Restaurant. My office is on the lower level, beneath Linda’s Sew Unique.

Parking:

Directly across the street, behind Bove’s, there is a parking lot with meters that cost a quarter for 30 minutes. The meters on the street give you 20 minutes per quarter.
Sometimes there are free spots available on Pine, right along the building. You can park for free in the parking lot at Cathedral of the Immaculate Conception on Pine St. in the afternoon when their masses are not in service. During services they have orange cones blocking the lot. Also, the mall parking garage is just a block away (Pine and Cherry) and is free for the first 2 hours.

INTAKE AND HISTORY

Date ______________________

Confidential Record: Information contained here will not be released except when you have authorized us to do so.

Name ______________________ Date of birth ____________ Age ________

please indicate preferred ways to contact you

Address (Street) ______________________ Home phone ______________________

City/State/Zip ______________________ Cell phone ______________________

Employer ______________________ Work phone ______________________

Type of work/title ______________________ Email ______________________

Referred by (or where did you hear of us?) ______________________ Employer/phone ______________________

Parent/Guardian (if patient is a minor) ______________________ Physician name/phone ______________________

Partner's name ______________________ Marital status ______________________

In case of Emergency notify: Name/Phone ______________________

Reason for present visit ______________________

____

Have you had any of the following illnesses?

- ☐ Rheumatic Fever
- ☐ Angina Pectoris
- ☐ Heart Attack
- ☐ Other Heart Disease
- ☐ Stroke
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Varicose Veins
- ☐ Bleeding Disorder
- ☐ Anemia
- ☐ Kidney Disease
- ☐ Frequent Kidney or Bladder Infections
- ☐ Frequent Lung Infections
- ☐ Asthma
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Cancer
- ☐ Thyroid Disease
- ☐ Diabetes
- ☐ Ulcers
- ☐ Colitis
- ☐ Other Stomach Disease
- ☐ Gallbladder Disease
- ☐ Jaundice
- ☐ Hepatitis/Liver Disease
- ☐ Gout
- ☐ Arthritis
- ☐ Migraine Headache
- ☐ Abnormal PAP Test
- ☐ Alcoholism
- ☐ Others ______________________

____

women:

- ☐ Menstruating now
- ☐ Pregnant now

Please indicate any painful, numb, sensitive or injured areas on the figures:

Describe the sensation:

- ☐ stabbing
- ☐ dull ache
- ☐ burning
- ☐ radiating
- ☐ constant
- ☐ intermittent
- ☐ other

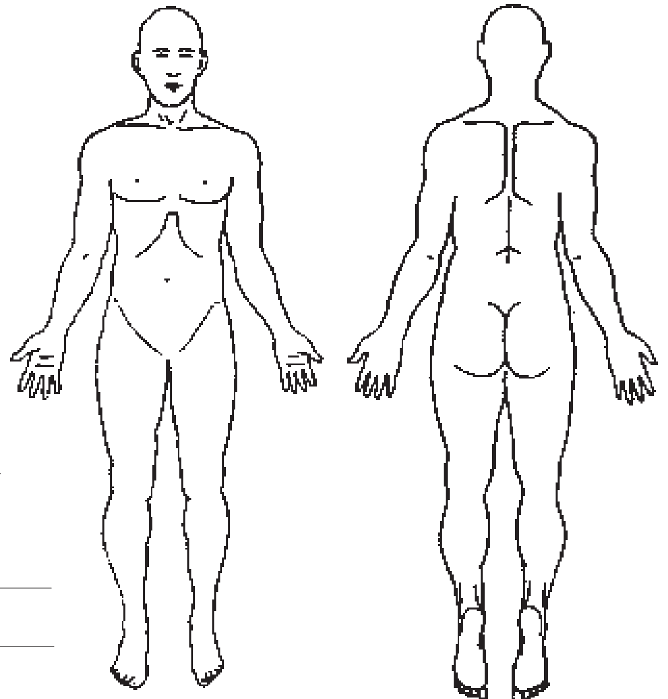
Rate the severity of the sensation from 1-10

(10 being most sensation) ______________________

Does your pain/sensation interfere with:

☐ Work? ☐ Sleep? ☐ Daily routine? ☐ Other? ______________________

____



Operations: List and indicate approximate year. ____________________

____

Hospitalizations (other than operations): List reasons and approximate dates. ____________________

____

Serious injuries (other than the above): List and give approximate dates. ____________________

____

Diagnostic X-rays: List and give approximate dates. ____________________

____

Please list the location of all major scars, surgical & otherwise. ____________________

____

Check if any blood relative has or has had any of the following:

- ☐ Stomach Ulcers
- ☐ Kidney Disease
- ☐ Cancer
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Migraine
- ☐ Asthma
- ☐ Diabetes
- ☐ Bleeding Disorder
- ☐ Allergies
- ☐ Arthritis
- ☐ Colitis
- ☐ Nervous Breakdown/Mental Illness
- ☐ Gout
- ☐ Alcoholism

Please list all medications, with dosage: ____________________

____

Please list all vitamins and other supplements, with dosage: ____________________

____

Do you have any allergies? No ☐ Yes ☐ If yes, to what? ____________________

____

Do you exercise? No ☐ Yes ☐ What do you do and how often? ____________________

____

What does your diet primarily consist of? ____________________

____

Do you:
Drink soda? No ☐ Yes ☐ How much and how often? ____________________

Drink coffee? No ☐ Yes ☐ decaf ☐ How much and how often? ____________________

Drink tea? No ☐ Yes ☐ What kind, how much and how often? ____________________

Drink alcohol? No ☐ Yes ☐ What kind and how often? ____________________

Smoke? No ☐ Yes ☐ How many per day? ____________________ Quit smoking __________ ago.

Which of these do you like during your session? Check all that apply. quiet ☐ music ☐ conversation ☐

Have you ever had acupuncture before? yes ☐ no ☐ *if yes, where?* ____________________

Have you ever had Thai Bodywork before? yes ☐ no ☐ *if yes, where?* ____________________

Have you ever had Zero Balancing before? yes ☐ no ☐ *if yes, where?* ____________________

What level of pressure or strength do you like for bodywork? light ☐ medium ☐ strong ☐ extra strong ☐

Name:_________________________________ Date: _______________

Please check all that apply currently:

General *yes*

Sudden energy drop?............................ ☐
Morning ☐ Afternoon ☐ Evening ☐
Often feel weak? .... ☐
If localized, where?____________________
Fatigue? .... ☐
Always or frequently thirsty? .... ☐
warm drinks ☐ cold drinks ☐
When ill, do you recover quickly? .... ☐
or does it take a long time? .... ☐
Recent weight gain or loss? .... ☐
Have you taken a lot of antibiotics in the past? ☐
Were you vaccinated as a child? ☐as an adult?☐
Do you usually feel colder than others?.......... ☐
warmer than others? .... ☐
strong dislike for cold weather? .... ☐
warm weather? .... ☐
Cold hands and feet? .... ☐
Do you feel warm or feverish in the evening? ... ☐
Night sweats? .... ☐
Chills? .... ☐
Fevers? .... ☐
Tremors? .... ☐
Poor balance? .... ☐
Perspire easily with little exertion? .... ☐
Difficulty sleeping? .... ☐
Never ☐ Sometimes ☐ Often ☐
Trouble falling asleep? .... ☐
Frequent waking up? .... ☐
Waking early in the morning, when? ________ ☐
Dream disturbed sleep? .... ☐
Nightmares? .... ☐
Other sleeping problems? _________________
Frequent sighing? .... ☐

Nervous System

Headaches? .... ☐
Constant ☐ Often ☐ Sometimes ☐
Dizziness? .... ☐
Fainting spells? .... ☐
Seizures? .... ☐
Numbness or tingling? .... ☐
Wandering or transient pains? .... ☐
Poor memory? .... ☐
Concussion? .... ☐
Other neurological problems? ______________

Skin

Bruise easily? .... ☐
Itchy? .... ☐
Rashes? .... ☐
Unusually dry skin, lips or mouth? .... ☐
Dry scalp or dandruff? .... ☐
Unusually oily skin? .... ☐
Frequent or chronic pimples or acne?............ ☐
Sores or wounds that do not heal? .... ☐
Eczema or psoriasis? .... ☐
Loss of hair? .... ☐
Other hair changes _______________________

Gastrointestinal *yes*

Bad breath? .... ☐
Bad taste in mouth? .... ☐
Difficulty swallowing? .... ☐
Indigestion or heartburn? .... ☐
Excess belching? .... ☐
Excess gas? .... ☐
Any special food that cause you difficulty? ...... ☐
Can you eat most foods without difficulty? ...... ☐
Poor appetite? .... ☐
Recent change in appetite or eating habits? .... ☐
Do you need to maintain a limited diet? .... ☐
Stomach pain? .... ☐
worse after meals ☐ better after meals ☐
Feel bloated after meals? .... ☐
Frequent nausea or vomiting? .... ☐
Vomiting blood? .... ☐
Abdominal pain or cramping? .... ☐
Constipation? .... ☐
Loose stools? .... ☐
Chronic diarrhea? .... ☐
Alternating constipation/loose stools? .... ☐
Blood in stools/black stools? .... ☐
Recent change in bowel habits? .... ☐
Hemorrhoids? .... ☐
Rectal pain or burning? .... ☐
Use laxatives? .... ☐

Eyes Ears Nose Throat

Glasses/contacts? .... ☐
Poor vision? .... ☐
Glaucoma? .... ☐
Cataracts? .... ☐
Poor night vision? .... ☐
Pain in your eyes? .... ☐
Spots in vision? .... ☐
Colorblindness? .... ☐
Dry, itching eyes? .... ☐
Frequent tearing? .... ☐
Ear pain? .... ☐
Hearing loss? .... ☐
Recent ☐ Chronic ☐
Ringing in ears? .... ☐
High ☐ Low-pitched ☐
Chronic nasal congestion? .... ☐
Chronic sinusitis? .... ☐
Sneezing? .... ☐
Inability to smell? .... ☐
Frequent nosebleeds? .... ☐
Constant dry throat? .... ☐
Chronic or recurrent sore throat? .... ☐
Always needing to clear your throat? .... ☐
Sensation of lump in throat? .... ☐
Recurrent sores on lips, tongue or cheeks? .... ☐
Bleeding gums? .... ☐
Jaw tightness, pain or clicks? .... ☐
Grinding teeth? .... ☐
Lots of fillings or dental problems? .... ☐

Respiratory *yes* *no*

Do you breathe as easily as you would like? … ☐ ☐
Asthma? … ☐
Emphysema? … ☐
Bronchitis? … ☐
Pneumonia? … ☐
Constant cough? … ☐
Coughing up blood? … ☐
Excess phlegm? Color ________________ ☐
Shortness of breath? … ☐

Cardiovascular

High blood pressure? … ☐
Low blood pressure? … ☐
Irregular heartbeat? … ☐
Palpitations? … ☐
Chest pain or tightness? … ☐
Worse with exercise or exertion? … ☐
Worse when lying down? … ☐
Trouble breathing at night? … ☐
Difficult breathing, especially when lying down? ☐
Cough at night when lying down? … ☐
Leg cramps with walking or exercise? … ☐
Phlebitis? … ☐
Feet/ankles or hands swelling? … ☐
Blood clots? … ☐

Musculoskeletal

Aware of any structural misalignments? … ☐
Scoliosis ☐ Unequal bone growth ☐
Neck pain? … ☐
Shoulder pain? … ☐
Mid back pain? … ☐
Low back pain? … ☐
Joint pain? … ☐
Which joints? ____________________ ☐
Does your joint pain seem to move around? … ☐
Is your pain increase by cold? … ☐
heat? … ☐
damp weather? … ☐
pressure? … ☐
Is your pain improved by cold or ice? … ☐
heat? … ☐
touch or pressure? … ☐
What else eases your pain? _______________
____

Urogenital

Urinate frequently? … ☐
Urinate large amounts of clear urine? … ☐
Is your urine dark and scanty? … ☐
Pain or burning with urination? … ☐
Ever passed blood in your urine? … ☐
Get up at night to urinate? … ☐
How many times? __________
Trouble urinating? … ☐
Decrease in the force of your stream? … ☐
Dribbling urine? … ☐
Lose urine with cough, sneeze or laugh? … ☐
Frequent bladder or kidney infections? … ☐
History of herpes or other venereal infections? ☐
History of yeast infections? … ☐

Mental-Emotional *yes*

Depression? … ☐
Anxiety? … ☐
Frequently irritable, or irrationally angry? … ☐
Frequent mood swings? … ☐
Nervous Breakdown? … ☐
PTSD or Violent Crime Victim? … ☐
Ever been treated for mental illness? … ☐
Ever considered or attempted suicide? … ☐
Other psychological concerns? _____________
____
____

Men

Prostate problems? … ☐
Trouble getting or maintaining an erection? … ☐
Any unusual or irregular discharge? … ☐
Pain in the scrotum or testicles? … ☐
Chronic or recurrent itching? … ☐
Vasectomy? … ☐

Women

Number of pregnancies _____
Number of deliveries _____
Number of miscarriages _____
Number of abortions _____
Hysterectomy? … ☐
Tubal ligation? … ☐
Ever used birth control pills? … ☐
Unusual vaginal discharge? … ☐
Last PAP smear _____________
Breast lumps? … ☐
Breast sore or tender? … ☐
Bloating before periods? … ☐
Mood swings before periods? … ☐
Irregular periods? … ☐
Typical menstrual flow lasts _____ days?
Average number of days in cycle _______
Light flow? … ☐
Moderate flow? … ☐
Heavy flow? … ☐
Clots? … ☐
Cramping or pain with periods? … ☐
before? … ☐
during? … ☐
after? … ☐
Describe pain: dull ☐ sharp ☐ other _________
Low back pain with period? … ☐
What do you do for the pain? ______________
When was your last period? _____________
Age of menarche (first period) ____________
Menopause? age of onset _____________ ☐
Hot flashes? … ☐
Night sweats? … ☐
Dry eyes, skin, vagina? … ☐
Emotional changes? … ☐

Is Is there anything not asked here that you would like to add?

____
____
____

CONSENT FORM

I hereby authorize Kelly Kaeding MS LAc to treat me using Oriental medicine and relevant treatment modalities. I understand that Oriental medicine includes the use of acupuncture, acupressure, Thai and Oriental bodywork, moxibustion, cupping, and other methods to stimulate acupuncture points, meridians and overall body energy. Relevant treatment modalities may include craniosacral therapy and zero balancing. Kelly may also make dietary and herbal recommendations based on Oriental medical theory. I recognize that there are potential risks involved with acupuncture, such as discomfort, minor bruising, infection at the site of needle insertion, needle sickness, and temporary worsening of my symptoms. I also recognize that while acupuncture and Oriental medicine provide the potential benefits of painless and drug-free relief of my presenting condition and prevention of recurrences, there is no implicit guarantee of a cure from this therapeutic approach.

- ❑ **I understand all the information on this page and give consent for treatment.**

I acknowledge that I have been shown and have access to:

- ❑ The regulations regarding unprofessional conduct
- ❑ The method for filing a complaint
- ❑ The Notice of Privacy Practices for Protected Health Information

- ❑ I have read the Consent for Use or Disclosure of Health Information and agree to its terms. I am also acknowledging that I have access to this notice.

Please check above and sign below:

________________________________ __________
Signature of Client and/or Guardian date

____
Client Name (printed)

Would you like to receive informative newsletters or similar literature from my practice? I send e-newsletters a maximum of four times a year which include recipes and hints for keeping healthy.

Please check **all** that apply:

- ❑ yes, email
- ❑ yes, US mail
- ❑ no, none of the above

Can we leave messages for you on your answering machine?
circle: **no** **yes** (home) **yes** (work) **yes** (cell)
Can we leave messages for you with people who answer your phone?
circle: **no** **yes** (home) **yes** (work)
(Note: messages usually concern appointment times or answers to your questions)