ELEMENTAL THERAPY

BODY | MIND | SPIRIT

Welcome to Elemental Therapy! I am so excited 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.

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 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 moxibustion and needles. The changes that you feel during a treatment can be subtle or profound. These sessions are approximately 45 - 60 minutes.

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 1-2 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 due to 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 (Artemesia Vulgaris) used to warm acupuncture points by placing a small lit cone on the skin that are removed when you feel warmth. In addition I may use acupressure, cupping, gua sha or Bowen therapy to enhance your acupuncture treatments. Zero Balancing may also be used, and 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, Venmo 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, unless paid in advance through Acuity scheduling. 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 with a Traditional Diagnosis (which includes your first acupuncture treatment) is $150. Each subsequent treatment = $140 (Acuplus/90 min), or $95 (SimplyAcu/45 min). (Students are offered a sliding scale for these treatments, must have student id, and be currently attending classes).

Please see ElementaltherapyBoulder.com for descriptions of all offerings. You can schedule your appointments from this website, as well.

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 (206) 399-6370 or email Elementaltherapyboulder@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, or text message. If you are running late to an appointment, a text message is helpful.

Directions: My office is located at *1800 30th Street, Ste. 201A, Boulder CO 80301.* (Located between Canyon and Walnut on 30th.) Going North on 30th turn right just past the Jiffy Lube. 1800 (Commons) is behind the Sussex Bldg. There is ample parking under the building. My office is on the second floor, at the North end of the bldg. Please call or text if you have any problems finding it.

Elemental Therapy treatments can be a powerful, transformative and an integral part of your healing journey. I look forward to working together to relieve the symptoms you may be experiencing, while providing a foundation for rediscovering your internal spark and enabling you to live the life of your dreams.

Sincerely,

Kat Talley

Name: ____ Todays Date ________________________________

Address: ___________________________________ City: ________________ State: ______ ZIP: _________

Primary Phone #: _______________________________ Can I text this #? Yes/No

Can I leave a voice message? Yes/No

E-mail: _______________________________________

Emergency Contact Name: ______________________ Phone #: _______________

Relationship: ______________________

How did you hear about Elemental Therapy? ____

Birth Date: _____________ Age: ____________

Gender Identity:_________________________

Occupation: _____________________________

Are you a student? _______________________ Primary Physician: _______________________

Phone #: ______________________ Are you married? Yes/No

Spouse or Partner's Name: ___________________________ Do you have children? Yes/No
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:

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
▫ 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,			

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 ___________________________