East Winds Acupuncture
WHERE EAST SPANS WEST

WELCOME LETTER

Welcome to East Winds Acupuncture; we look forward to working with you on your journey to health.

We are committed to helping you and will focus our efforts toward assuring you a pleasant experience as well as an excellent outcome. We feel that it is vital that you commit yourself to the "plan" that we recommend for you upon your first visit with us.

On that note we ask that you comply with the following cancellation policies.

- We reserve the right to charge you for appointments cancelled or broken without 24 hours advance notice, at full cost of treatment.
    - Appointment cancellations should be made 24 hours in advance of your scheduled appointment time. We understand emergencies do arise. We simply ask that you extend the courtesy to fellow patients, by letting us that you need to cancel. This will allow us to open your time slot for another patient as well as reschedule your appointment.
- Your care is important to us and we make every effort to accommodate your busy schedule. However, if you are more than 10 minutes late for an appointment, and it cannot be rescheduled the same day, you have the option of accepting a shortened acupuncture session, or paying for a missed appointment.

As of January 1st, 2015 we will require a credit card when scheduling all New Patient appointments.
If you do not show for your appointment, your card will be charged 50% of the new patient fee which will be a total of $67.50.

Our goal is to help you and many other patients experience the benefits of acupuncture and Oriental Medicine. We block off two hours for all new patients. If you no-show without giving 24 hours' notice, that time is not available for another patient who may need an appointment. We know you understand.

Our goal is high quality, efficient care, and to accommodate all patients who would like to be seen by Dr. Diane.

Please sign this form and bring it with you completed health history forms. It is important that you fill ALL sections and pages of these forms so we don't waste precious one on one time with Dr. Diane.

Thank you.

Sincerely;
Diane Cridennda L.Ac FABORM NCCAOM

Date: _____

Patient Name (print): _____ Patient Signature_____

Health History Questionnaire – Female Fertility

1422 N. Hancock, Suite 5 South, Colorado Springs, CO 80903 ☯ www.eastwindsacupunture.com ☯ P 719-520-5056 F 719-520-5222

Important: Complete this document as thoroughly as possible. Some questions may seem unrelated to your condition, but they may affect your diagnosis and treatment. All information is confidential.

Date	First Name	Last Name	Middle Initial
_____ / _____ / _____			

Gender	Date of Birth	Age	Eye Color:	Height:	Weight:
M F	_____ / _____ / _____				

Street Address	City	State	Zip

Phone (Daytime) – **Home Work Mobile** *Circle One* ( )	Phone (Nighttime) # **– Home Work Mobile** *Circle One* ( )
Alternate Phone # **– Home Work Mobile** *Circle One* ( )	Place of Employment / Occupation
Name & Phone Numbers of Partner: Primary ( ) Alternate ( )	Name & Phone Numbers of Emergency Contact: Primary ( ) Alternate ( )

E-Mail:

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

If you would like to receive information from East Winds Acupuncture check here ☐

How did you hear about us? *Please circle one and write the name*

Current Patient: __________ Doctor: __________Advertisement: __________ Friend: ________Insurance: ___________ Other:___________

Have you received a Diagnosis for your condition(s)? Y / N If so what:

By Whom:

Have you had Acupuncture before? Y / N

Did you have a positive ☐ Experience ☐ Out come

	Severe	Moderate	Slight	Major Complaint(s), in order of **importance** to you:
1.	☐	☐	☐	______________________________
2.	☐	☐	☐	______________________________
3.	☐	☐	☐	______________________________
4.	☐	☐	☐	______________________________
5.	☐	☐	☐	______________________________

When/how did this condition occur? Give dates if possible. 1) ______________________________

2) ______________________________ 3) ______________________________

What treatments helped the most? 1) ______________________________

2) ______________________________ 3) ______________________________

How do these conditions impair your daily activities? 1) ______________________________

2) ______________________________ 3) ______________________________

Treatment(s) you have received for this Condition 1) _____

2) _____ 3) _____

SYMPTOMS – NOTE: For each symptom you currently have, rate its severity from 1-10 (10 being the worst). Leave blank if Not Applicable. Circle choice if two choices are given.

LIVER / GALLBLADDER

_____ Irritability / Anger
_____ Depression / Stress
_____ Headaches / Migraines
_____ Visual Problems
_____ Red / Dry / Itchy Eyes
_____ Gall Stones
_____ Dizziness
_____ Blurred Vision
_____ Feeling of Lump in Throat
_____ Clenching of Teeth at Night
_____ Muscle Cramping / Twitching
_____ Tension
_____ Joints/Neck/Shoulder Pain/Tight
_____ Poor Circulation
_____
_____ Soft / Brittle Nails
_____ Emotional Eater
_____ Bad Taste
_____ Bad Breath
_____ Do you Crave: Sour

KIDNEY/ URINARY BLADDER

_____ Urinary Problems
_____ Bladder Infection
_____ Dropped Bladder
_____ Incontinence
_____ Lack of Bladder Control
_____ Weakness/ Pain in Low Back
_____ Decrease Bone Density
_____ Feel Cold Easily
_____ Cold Hands
_____ Cold Feet
_____ Low Sex Drive / Libido
_____ Excess Sexual Desire
_____ Poor Memory
_____ Loss of Hair
_____ Hearing Problems
_____ Cavities
_____ Fear
_____ Hot Flash/ Night Sweating
_____ Do you crave: Salty

HEART/SMALL INTESTING

_____ Heart Palpitations
_____ Chest Pain
_____ Insomnia / Sleep Problems
_____ Easily Startled
_____ Restlessness / Agitation
_____ Vivid Dreams
_____ Lack of Joy in Life
_____ Do you crave: Bitter

LUNG / LARGE INTESTINE

_____ Bloody Cough
_____ Dry Cough
_____ Cough with Sputum
_____ Nasal Discharge / Circle Color - White Yellow Green
_____ Post Nasal Drip / Circle Color: White Yellow Green
_____ Sinus Infection/ Congestion
_____ Itchy, Red, or Painful Throat
_____ Dry Mouth/ Throat/ Nose
_____ Skin Rashes / Hives
_____ Snoring
_____ Grief / Sadness
_____ Shortness of Breath
_____ Allergies / Asthma
_____ Low Resistance to Colds or Flu
_____ Sneezing
_____ Mild Fever Comes & goes
_____ Smokes Cigarettes
_____ Emphysema
_____ Bronchitis
_____ Black / Blood in Stools
_____ Constipation
_____ IBS
_____ Colitis/ Spastic Colon
_____ Diarrhea
Do you Crave : Pungent

SPLEEN / STOMACH

_____ Heaviness Anywhere in the Body
_____ Fatigue on a Scale of 1(**low**) –10 (**high)**
_____ Hard to get up in the Morning
_____ Muscles Feel Tired Often
_____ Edema (swelling) □ hands □ feet
_____ Easily Bruising & Bleeding
_____ Bad Breath
_____ Nausea/ Vomiting
_____ Difficulty Digesting Fatty Foods
_____ Nausea/ Vomiting
_____ Gas / Belching
_____ Hemorrhoids
_____ Constipation
_____ Diarrhea
_____ Abdominal Pain
_____ Indigestion / Heartburn
_____ Over - Thinking
_____ Tendency to Gain Weight
_____ Brain Foggy
_____ Do you Crave: Sweet

MEDICATIONS – Please list all prescription medications you use. Include those which you may only use occasionally. Remember inhalers, eye drops, nose sprays, and topical creams. NOTE: If need more space, use page 6 under 'Notes/Anything Else'

Prescription Name	Purpose	How Long	Dose	How Often	Last Dose

On a scale of 1-10, rate your commitment to get rid of the problem(s) and feel better _____

Have you had acupuncture before? _____

If yes, who and where? _____

Any concerns or fears about the needles? _____ **If yes, what?** _____

_____

What are your goals from your acupuncture visits?

1. _____
2. _____
3. _____

PERSONAL MEDICAL & FAMILY HEALTH HISTORY

Please indicate those that are current health problems for yourself and your family members with a "**C**" under the appropriate person's column. "**P**" should be used to indicate a past problem. Leave blank those that do not apply. If you require more space, use the space below.

	You	Father	Mother	Spouse	Brother(s)		Sister(s)		Children		
Age											
AIDS / HIV											
Alcohol Abuse											
Anxiety											
Anorexia / Bulimia											
Arthritis											
Asthma / Hay Fever / Allergy											
Back Trouble											
Bursitis											
Cancer											
Constipation											
Depression											
Diabetes											
Digestive Trouble											
Headaches											
Heart Trouble											
Hepatitis											
High Blood Pressure											
Immune Disorder											
Insomnia											
Kidney Trouble											
Liver Trouble											
Migraine											
Neck Pain											
Thyroid Disorder											
Suicidal Tendencies/self/others											
Tobacco											
Weight Problem											
Other Emotional Problems:_____											
Other:_____											

If any of the above family members are deceased, please list their age at death and cause.

_____

SURGERIES (Including the removal of wisdom teeth)

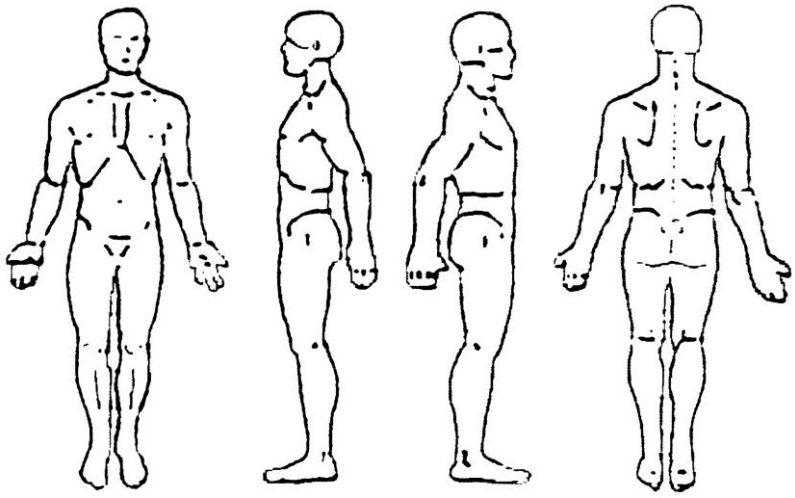
Date or Age	Type Of Surgery	Location of Scar

MUSCULOSKELETAL

☐ Muscle Cramps – Where?
☐ Joint Swelling – Where?
☐ Muscle Pain / Rheumatism – Where?
☐ Tendonitis – Where?
☐ Arthritis – Where?
☐ Bursitis – Where?

What Makes this Better? : ______________________________

Please mark problem areas on diagram:



Location of Pain

Is the Pain ☐ Sharp ☐ Burning ☐ Aching
☐ Fixed ☐ Numbness
☐ Tingling ☐ Other:________________

On a Scale of 1 (Low) – 10 (unbearable):

Is the Pain Better With: ☐ Rest ☐ Activity ☐ Ice
☐ Heat ☐ Other:_____________
☐ Massage ☐ ☐ Chiropractic

Location of Pain

Is the Pain ☐ Sharp ☐ Burning ☐ Aching
☐ Fixed ☐ Numbness
☐ Tingling ☐ Other:________________

On a Scale of 1 (Low) – 10 (unbearable):

Is the Pain Better With: ☐ Rest ☐ Activity ☐ Ice
☐ Heat ☐ Other:_____________
☐ Massage ☐ ☐ Chiropractic

Location of Pain

Is the Pain ☐ Sharp ☐ Burning ☐ Aching
☐ Fixed ☐ Numbness
☐ Tingling ☐ Other:________________

On a Scale of 1 (Low) – 10 (unbearable):

Is the Pain Better With: ☐ Rest ☐ Activity ☐ Ice
☐ Heat ☐ Other:_____________
☐ Massage ☐ ☐ Chiropractic

Location of Pain

Is the Pain ☐ Sharp ☐ Burning ☐ Aching
☐ Fixed ☐ Numbness
☐ Tingling ☐ Other:________________

On a Scale of 1 (Low) – 10 (unbearable):

Is the Pain Better With: ☐ Rest ☐ Activity ☐ Ice
☐ Heat ☐ Other:_____________
☐ Massage ☐ ☐ Chiropractic

For Men and Women
DIET INFORMATION

Please describe your appetite:
□ Strong □ Normal □ Poor

Do you hunger quickly? □ Yes □ No

Please describe your diet (avoid bad fats, low-carb, high protein, vegetarian)

_____

_____

Please list what you ate yesterday
Breakfast : _____
Lunch : _____
Dinner : _____
Snacks : _____

How much water do you drink per day? _____
Other fluids _____

Please describe your thirst
□ Strong □ Normal □ Poor

If you eat any of the following , please check and list how much <u>per week:</u>
□ Candy _____
□ Cookies/ Baked Goods _____
□ Chocolate _____
□ White flour bread _____
□ Soda – Regular/ Diet _____
□ Milk _____
□ Cheese _____
□ Alcohol _____
□ Fast Food _____
□ Protein _____
□ Dark Green Vegetables _____
□ Fruit _____
□ Other _____

Are there any foods that you eat that make you feel Bad/gas/bloating/indigestion? _____

Please list food allergies that have been diagnosed: _____

Women Only

Hysterectomy – Ovaries Removed? □ Yes □ No
Could You be Pregnant Now? □ Yes □ No

Number Of: ___ Pregnancies ___ Miscarriages
___ Births ___ Abortions

Post-menopausal Bleeding □ Yes □ No

When did your last period start? _____

Number of days for menstrual cycle? _____

Number of days bleeding lasts? _____

Describe Menstrual Flow:
□ Heavy □ Moderate □ Light □ None

Color of Menstrual Flow:
□ Merlot □ Bright Red □ Pink/Red
□ Bloody Mucous □ Brown □ Purple (Grape Jelly)

Birth Control:
□ None □ IUD □ Birth Control Pills
□ Spermicides □ Barriers

Do You Experience:

□ Vaginal Dryness
- □ Use lubricants during intercourse?
  Products used: _____

□ Cramping *(Mark as appropriate)*
- □ Cramping in Low Back
- □ Severe
- □ Mild
- □ During Period
- □ Do you us pain Medication?
- □ In Groin Area
- □ Moderate
- □ Before Period
- □ Do you feel Ovulation
- □ After Period

What Kind of Medication? _____

□ Clotting *(Mark as appropriate)*
- □ Bright in Color
- □ Stringy
- □ Brown / Grainy
- □ Dark in Color
- □ Size of Clots : Nickel / Dime / Larger

□ Bleeding Between Periods
□ Pelvic Inflammatory Disease
□ STD's
□ Endometriosis
□ Mastitis
□ Yeast Infection / Vaginitis / Other Discharge
□ Infertility
□ Ovarian Cysts
□ Hot Flashes
□ Breast Cysts

□ Premenstrual Syndrome *(Mark as appropriate)*
- □ Fluid Retention
- □ Fluctuating Emotions
- □ Tenderness in Breasts
- □ Fatigue
- □ Tender / Weepy
- □ Cravings
- □ Irritability
- □ Depression
- □ Loose Stool

Men Only

□ Impotence
□ Discharge from Penis
□ Testicular Pain or Lump
□ Premature Ejaculation
□ STD's
□ Weak Erection
□ Prostate Problems
□ Infertility
□ Low Sex Drive

Men and Women

Supplements

Name	Purpose	How Long

Notes / Anything Else

Thank you for completing this form. Your time is greatly appreciated and we value this opportunity to serve you!

Female Fertility Form

Date _____ / _____ / _____	Age	Body Type	Height:	Weight:	Complexion:	Occupation:

Are you being treated by:

LMP: _____ Cycle Duration _____

RE & I Clinic / Fertility Specialist: RMFC / CCRM / FCC / Conceptions / CU

Other OBGYN doctor Start Date: Month/ Year

_____ _____

. Western Diagnosis _____

1. **How many times per week do you have intercourse? _____x per week**
2. **Do you use lube for vaginal dryness?**_____

3. Fertility treatments (including cancelled cycles):

Date	Natural, IUI IVF, Other	Medication Used	# of Mature Eggs / Follicles	Pregnancy Yes/No	If Miscarried , Indicate at which Week	Other Comments and Locations

4. Your Diagnostics / Date

Elevated FSH	Uterine Fibroids / Polyps	Endometriosis / Adhesions	PCOS	POF	Low Progesterone Level	PID	STD's	Herpes

Others:

5. If you have PCOS, are you taking:

Glucophage	Fortamet	How long?	Are you taking extra B-Complex Vitamins?

6. Female Health:

PID	Chlamydia	STD's	Herpes	Antisperm Antibodies	Others

7. Procedures performed / Dates

Laparoscopy	HSG-Hysterosalpingogram	Others:

8. Lab Results/ Dates

FSH Level Day 3	HCG	Prolactin	TSH	T3:	T4:	Free T4:	OAR	Others

9. Lab Results on File Y / N

9. Supplements and/or Vitamins?

Date	Prenatal	Fish Oil	Greens Plus	Antioxidants	Royal Jelly/ Propolis	Additional Folic Acid	Others

10. Planned ART / Date:

IUI w/ Injectables	IUI w/ Oral Meds	Clomid	IVF	PGD/CCS	Femara letrozole	other

11. Fertility History / Dates

Pregnancies	Children	Miscarriages	Abortions	Ectopics	D&C	Abnormal Pap Smear	Others

12. Other:

Age at which menses began? _____
Oral Contraceptive Pill? _____ How long? _____
List name of birth control
_____
How long have you tried to conceive? _____
Clomid challenge test? _____
Date:_____
Day 3_____ at Day 10_____ at _____(month/year)
Recurrent yeast infections? _____ How often? _____

Natural Ovulation …….. Y / N
Which day of your cycle are you on today _____ to ____
Typically, how many days are there from one period to the next _____ to _____ days?
Today is which day of your cycle? _____
Current month treatment plan _____
(Natural, IUI, IVF, Any Tests, etc.)

13. PMS

	10 Days Before	1 Week Before	2-3 Days Before
Breast Tenderness			
Depression			
Fatigue			
Low Back Pain			
Face Break Out			
Other			

14. Menstrual History

Symptoms (please check each day)	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6-7
Do you have Back Pain?						
Cramps (Light, Medium, Severe)						
Color (Light Red / Red / Dark Red / Brown)						
How Heavy is Flow (Light, Normal, Heavy)						
Is there Clotting?						
Is there Spotting?						

15. Is partner currently being treated by us? **Y / N**

16. Partner's Name _____

17. Western Diagnosis of the partner: _____

18. Do we have copies of labs / sperm analysis **Y / N**

19. Results for Sperm Analysis:

Date	Count	Morphology	Motility	Volume

20. Male Reproductive History/ Date:

Varicocele	Vasectomy	Vasectomy Reversal	SDSA/ DNA	Anti- Sperm Antibodies	Others

21. Following Fertility:

Basal Body Temperature Chart Y / N
Timed Sex …… Y / N
Stress Reduction …… Y / N
Diet Principals : □ Yin
□ Yang
□ Blood
□ Qi

<u>Ovulation</u>

(LH) Luteinizing Hormone Sticks Y / N
(OPK) Ovulation Predictor Kit Y / N
Relationship / Sex …….. Y / N

Avoid Ice cold Foods……... Y / N
Avoid Tampons…… Y / N
Femoral Massage …… Y / N
Visualization……. Y / N
Meditation ……... Y / N
Yoga ……. Y / N
Qi Gong……. Y / N
Deep Breathing…… Y / N
Journaling……. Y / N
Foot Soaks…… Y / N
Feminine Hygiene…… Y / N
Detox……..... Y / N
Type of Detox
Feng Shui…….. Y / N

Diane Cridennda, L.Ac. NCCAOM FABORM
1422 North Hancock Suite 5 South
Colorado Springs, CO 80903
P (719) 520-5056 • F (719)-520-5222
info@EastWindsAcupuncture .com

NEW PATIENTS: *Please do not come hungry.*
Do not scrub, scrape or brush your tongue.
We need to see it in its natural state.
It is Ok to brush your teeth. Plan to be here ***at least*** *2 hours for your initial intake and treatment.*

Disclosure & Fee Schedule

Acupuncture Fee Schedule: fees due upon service

$135.00 Initial Visit (health history, evaluation & treatment)
$80.00 Follow-up Acupuncture Visit
$70.00 Herbal Consult
$130.00 Lab Interpretation & Consult
$85.00 Pre or Post transfer during office hours
$100.00 On Call (outside of office hours)
$160.00 On Site IVF pre or post transfer
$15.00 Per 15 minutes phone/email consultation
$70.00 Initial Visit for Pediatrics
$50.00 Sho Ni Shin/ Gua Sha (Pediatrics)
$ 1.00 /per min. Moxa/Cupping & other Acupuncture Modalities

Discount Packages

100% transferable and 100% refundable
24 Visits $1,560 ($65 per treatment)
12 Visits $840 ($70 per treatment)
6 Visits $450 ($75 per treatment)

Herbs & Supplements

purchased separately*
All sales on Herbs and or Supplements are final.
All Special Order herbs or supplements require payment in full prior to ordering and are subject to a 50% restocking fee if returned.

CANCELLATION POLICY:

We reserve the right to charge you for appointments cancelled or broken without 24 hours advance notice.
If you are more than 10 minutes late for an appointment, and it can't be rescheduled the same day, you have the option of accepting a shortened acupuncture session, or paying for a missed appointment.
We allow a one-time grace with a GOOD reason.

PROFESSIONAL AND ETHICAL STANDARDS:

You, the patient are entitled to receive information regarding methods of therapy, techniques used and duration of therapy. As a patient you may seek a second opinion from another health care professional, and may terminate therapy at any time. In a professional relationship, sexual intimacy is not appropriate and should be reported to the division of regulations (address provided below)

The practice of acupuncture is regulated by the Department of Regulatory Agencies. Questions or complaints should be addressed to:

Jenny Davis- Office of Acupuncture Licensing
1560 Broadway, Suite 1340, Denver, Colorado 80202-5140
303-894-7851 fax 303-894-7802

We comply with all rules and regulations promulgated by the Department of Health and Environment, especially those related to proper sanitation of acupuncture offices. We use disposable needles only.

PATIENT POLICY:

We will recommend a treatment plan according to your specific needs. Some conditions require more treatments than others. In order for you to experience a successful course of treatment for your problems, it is important that you commit to and follow this treatment plan

TREATMENT:

Acupuncture has been explained to me as a treatment consisting of the insertion of needles through the skin at specific points on the surface of the body (small amounts of electrical current may be applied to the needles). The purpose of acupuncture has been explained as the alleviation of symptoms or disorders.

I understand that complications may result from an acupuncture treatment. Among these possible complications are: areas of anesthesia, fainting, weakness, nausea, hematoma, infection, pain and discomfort, pneumothroax, and aggravation of present symptoms. Being tired, hungry, or stressed can on occasion make the body more sensitive to the acupuncture treatment. Please tell your provider if you have any conditions that may inhibit blood clotting, such as hemophilia or Coumadin use. Please use caution when walking with bare feet in the treatment room.

Acupuncture, acupressure, Moxa, cupping therapy, and nutritional or herbal counseling are considered experimental procedures and are not considered a substitute for Western Medicine. Therapies and advice offered shall not be construed by the client to be a diagnosis of treatment of any disease or injury. We recommend that you consult your physician for any serious conditions and receive at least two medical opinions. It is your right and responsibility for your own body.

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 of this clinic, in the event of accidental injury on these premises.

DIANE K. CRIDENNDA EDUCATION AND EXPERIENCE:

- St. John's School of Radiologic Technology, St. Paul, MN. Graduated 1972
- International Institute of Chinese Medicine, Santa Fe, New Mexico – Graduated 1995 with a Masters of Oriental Medicine degree. This degree includes classroom and clinical training in acupuncture, moxibustion, cupping, electrical stimulation and nutritional counseling. Total hours of study were 1942 and 129.5 college credits.
- China Study Program at the Sino-Japanese Friendship Hospital, Beijing, China, summer of 1995. Studies included acupuncture, herbology, qi gong and tui na.
- February 1996 certified by the National Commission for the Certification of Acupuncturists – Certificate #9511018410.
- Colorado licensed and member of the Acupuncture Association of Colorado. Colorado license #337.
- Conducting and presenting research on combining acupuncture with high tech fertility.
- Founding Member of the ABORM (American Board of Oriental Reproductive Medicine)

SARA SUPINSKY:

- Graduated from Southwest Acupuncture College Boulder Co in 2012 where she completed her Master of Science in Oriental Medicine.
- She also completed aclinical internship in China at Heilongjiang University (Harbin) focused on women's health and pediatrics.
- Nationally certified by National Commission for the Certification of Acupuncturists.

PAYMENT:

Payment is expected at time of service unless other arrangements have been made. Your signature on this document indicates you agree to pay for any other outstanding bills incurred by this office.

PLEASE INITIAL THE BOXES BELOW

[ ] A photocopy of this form shall be deemed as valid as the original.
[ ] I understand that if I am going to be more than 10 minutes late, EWA will suggest that I reschedule. Additionally, if I can be seen on the same day I will not be charged.
[ ] I understand that all sales are final on Herbs & Supplements and am subject to a 50% restocking fee if returned.
[ ] I understand that if I choose not to use the remainder of a package pricing, I will be reimbursed according to the usual fee structure that is not discounted. I also understand that this may cause a balance to be paid. ***No exceptions.***
[ ] I **HAVE READ AND UNDERSTAND ALL THE ABOVE INFORMATION.**

_____ or _____

_____

Patient Signature Guardian Signature Date

Email has been helpful for many of our patients as a way to check in for quick answers to simple questions and to have brief consultations between visits. However, when significant time is involved in evaluating and responding to these consultation requests, we now charge $10.00 for every 5 min. increment. This allows us to continue offering email as an option for patient communication. This fee applies only to patients' health related questions between office visits. There is no charge for brief questions with simple answers (such as yes, no, etc.), for supplement/herb orders or other administrative tasks. Thanks for understanding.