Lisa Ledbetter, L. Ac.
Live Well
3900 S. Wadsworth Blvd Suite #400
Lakewood CO, 80235

New Patient Intake Form

Name (Last, First, M) _____

Social Security (for insurance)_____-_____-_____ **Sex**_____ **Date of birth**_____/_____/_____ **Height**_____ **Weight** _____

Address _____

City_____ **State**_____ **Zip**_____

Occupation_____ **Employer** _____

Phone (C) (_____)_____ **(W)** (___) _____

Email (for office newsletter) _____

Emergency Contact_____ **Relationship** _____

Phone (_____)_____ **Referred by** _____

Thank you for choosing me as your health care practitioner. Colorado law requires that all acupuncturists provide the following information to patients on the first visit. Please take the time to read this document and sign it. I am looking forward to serving you and helping you with your health care needs.

Credentials

Lisa K. Ledbetter, L.Ac, Dipl.Ac. has attained the following credentials:
B.Sc., Colorado State University, 1996 (4 years of training)
Diplomat, Colorado School of Traditional Chinese Medicine, 1999 (1800 hours of training)
Diplomat, Acupuncture, NCCAOM, 1999-Present (1800 hours plus passage of board exam)
Licensed Acupuncturist with the State of Colorado, 1999-Present
Professional Member, Acupuncture Association of Colorado, 1998- Present

Scope of Practice

The focus of this practice is Oriental Medicine. Lisa K. Ledbetter, L. Ac., Dipl. Ac. is certified to offer treatments which include acupuncture as well as the prescription of Chinese herbs. Other permitted therapies which may be included in the treatment include electrical stimulation, moxibustion, cupping, Chinese therapeutic massage (tui na), Chinese dermabrasion (gua sha), and advice about diet and lifestyle.

Statement of Ethics

a) Lisa Ledbetter, L.Ac. Dipl.Ac. complies with all rules and regulations specified by theColorado Department of Health. She follows clean needle technique, using sterilized disposable needles, and follows state guidelines for sanitation and sterilization within the treatment room.
b) Patients are entitled to receive information about the methods, techniques, and duration of treatment offered. Patients may also seek a second opinion from another health care professional or may terminate treatment at any time.
c) In a profession relationship, sexual intimacy is never appropriate and should be reported to the Director of the Division of Registrations in the Department of Regulatory Agencies (DORA).
d) Acupuncture is regulated by DORA. Any complaints should be directed to:

Department of Regulatory Agencies
Office of Acupuncturists Registration
1560 Broadway, Suite 680 Denver, Co 80202
(303) 894-2464

Fees

First visit regularly **$125**, new patient special as of 12/18 **$75**
Follow up visit(s) **$70**
Children (under 12) **$60** first visit, **$40** follow up visit(s)
Pre-payment of 5 or more treatments **Save 10%**

**Chinese Herbal Medicines priced separately*

Payment Policy

Payment for services rendered is expected at the end of each visit. Acceptable forms of payment are cash, personal check or Visa / MasterCard. There will be a $25 charge for returned checks. Insurance can be billed on a case by case basis for auto accidents or group health benefits with a doctor's referral.

Cancellation / No Show Policy

Your appointment time has been reserved specially for you. Failure to show up for your appointment robs others the opportunity to receive needed treatment. If you wish to cancel your appointment, we request 24 hours notice to allow other patients to schedule if necessary. If you fail to arrive to your appointment and do not notify us, we will add $25 to your next appointment. We regret that patients who repeatedly cancel or fail to show up for appointments will be referred elsewhere for treatment.

I have read and understand the above information.

_____ ___/___/_____

Signature **Date**

HIPAA Privacy Policies and Injection/Intradermal Therapy Consent

Please visit the **Forms section** of the http://naturalhealthacupuncture.com website to read the HIPAA Privacy Policies and Informed Consent Injection/Intradermals Therapy consent forms. After reading, please sign below to acknowledge that you have read and understand the forms.

HIPAA Privacy Policies

Acknowledgement:

I acknowledge that I have read a copy of the HIPPA Notice of Privacy Practices that is posted to the website.

_____

Print Patient name or Personal Representative

_____ _____/_____/_____

Patient or Personal Representative Signature **Date**

If Personal Representative's Signature appears above, please describe Personal Representative's relation to patient:

_____

_____

Informed Consent Injection/Intradermals Therapy

I, _____, hereby request and consent to injection therapy on my body, in order to enhance the effect of stimulating an acupuncture point. I understand that I will only be injected with substances that fall within the scope of practice of Licensed Acupuncturists in Colorado. I understand the risks involved. I do not expect my practitioner to be able to anticipate all risks and complications. I have read and understand the Informed Consent Injection/Intradermals Therapy form located on the website. By signing below, I agree to accept all risks and release all liabilities from Lisa Ledbetter L.Ac.

Patient's Signature_____**Relationship**_____**Date**_____
(or representative)

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Patient Medical History

Name: (Last, First, Middle)_____Date:____/____/____

Marital Status:_____Children: (list ages) _____

Main problems / reasons for this appointment:

What treatments have you already had for these conditions and what was the result:

What was the diagnosis:

What alleviates the problem:

What makes the problem worse:

In general my symptoms are better in: AM Midday PM My symptoms do not change throughout the day

Are your symptoms: Improving Unchanged Getting worse

What is the level of your complaint? (circle) None – 0 1 2 3 4 5 6 7 8 9 10 - Agony

Additional concerns you would like addressed:

Allergies: Please list any drug or food allergies

Major Stress in the last six months:

Contagious Diseases / Significant Illnesses:

__HIV/AIDS Hepatitis Herpes Autoimmune disease Cancer Diabetes Gallstones Thyroid disease

__Venereal Drug Addiction Alcohol abuse Seizures

Major Surgeries: (Date / Description)

Major Traumas: (car accidents, falling, etc.)

Current Medications: Dose: Times/Day:

Current Herbs, Vitamins and Supplements: Dose: Times/Day:

What do you eat/drink in a typical day?

Breakfast

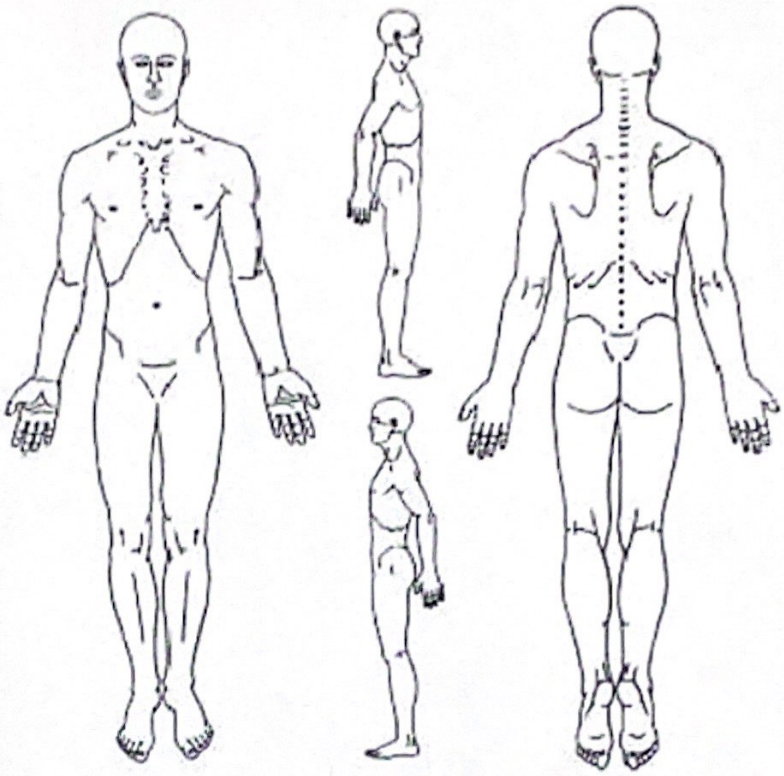
Lunch

Dinner

Snacks

Current Complaints: Place a circle on any area of pain or complaint and use the following symbols to describe what you are feeling.

A – Aching
S – Sharp / Stabbing
B – Burning
N – Numbness
T – Tingling / Pins and Needles
O - Other



Your Health Care Team

Family Physician:_____Phone: (_____) _____

Other Specialist:_____Phone: (_____) _____

Have you ever seen a:

Chiropractor: Yes / No Name: _____

Acupuncture: Yes / No Name: _____

Massage therapist: Yes / No Name: _____

Health History

Please check any symptoms you currently have or have had in the past year.

Body Temperature

__Warm natured Cold natured Cold hands and feet Flushed face Feel warmer at night Alternating chills/fever

__Night sweats Hot flashes Profuse sweating Palm sweating Feet sweating Very little sweating

Thirst

__Rarely thirsty Thirsty, but do not drink Always thirsty Prefer cold beverages Prefer hot beverages

Eyes

__Cataract Tear easily Blurred vision Corrected vision Red/inflamed Spots in vision (floaters) Dry Itchy

__Night Blindness Twitching Pain / strain

Ears

__Earache Ear discharge Ringing (High pitch Low pitch) Hearing loss

Nose

__Nasal obstruction Nasal discharge Nosebleeds Stuffy Sneeze Allergies Loss of sense of smell

Mouth and Throat

__Phlegm in throat Feeling of lump in throat Swollen gums Hoarseness Recurrent sore throat Sores on lips

__Sores on tongue Taste change Teeth problems Swollen glands Bitter taste

Head

__Heaviness in the head Light headed Headache Migraines Sinus pressure Sinus pain

Respiratory

__Asthma Hay fever Persistent cough Dry cough Coughing blood Shortness of breath Recurrent bronchitis

__Cough with phlegm Difficulty inhaling Difficulty exhaling Tight chest

Cardiovascular

__Chest pain High blood pressure Low blood pressure Irregular heart beat Palpitations Poor circulation

__Swelling of ankles Varicose veins Hypochondriac pain Distention in chest High cholesterol

Gastrointestinal

__Abdominal pain Bloating Gas Constipation Hard stools Diarrhea/loose stools Bloody stools Hemorrhoids

__Laxative use Difficulty swallowing Poor appetite Heartburn/reflux Indigestion Belching Stomachache

__Nausea / Vomiting Nervous stomach Motion sickness Vomiting blood Sighs frequently Hiccups Bitter taste

__Bad breath

Diet/Lifestyle

__Vegetarian Healthy diet Eat fried foods Eat red meat Use drugs Smoke cigarettes Drink alcohol (drinks/week)

__Drink coffee (cups/day) Crave sweets Crave salts Use Sleep Aids Take steroids Exercise regularly

__Exercise excessively

Weight

__Underweight Normal for height Overweight Very overweight Recent weight gain Recent weight loss

Urination

__Dilute urine Dark urine Blood in urine Cloudy urine Burning urination Scanty urine Profuse urine

__Frequent urination Poor bladder control Urgency to urinate Night urination Bladder infections

Musculoskeletal

Pain, weakness, numbness in: Arms Feet / Ankles Hands / Wrists Joints Legs Hips / Sciatic Neck Shoulders

__Pain all over Cold limbs Pain in damp weather Knee problems Mid back pain Low back pain All over weakness

__Broken bones Arthritis Muscle spasms

Skin / Hair / Nails

__Broken blood vessels Blood not clotting Bruise easily Discoloration Dark circles around eyes Dry skin Oily skin

__Itchy skin Rashes / Eczema Acne Brittle nails Premature gray hair Dry, brittle hair Hair falling out

Neurological

__Fainting Nervousness Convulsions Paralysis Stroke Seizures Tremor Recent clumsiness Drowsiness

__Vertigo Dizziness Poor memory (Long term Short term)

Emotional / Sleep

__Insomnia Hard to fall asleep Wakes frequently Troubling dreams Irritability Often feel angry Cry easily

__Feel sad a lot Feels restless Forgetful Mind not clear Anxiety Much fear Lack of joy

__Have difficulty making decisions Difficulty expressing emotions Fatigue / Low energy

Men Only

__Genital pain Impotence Genital sores Lump in testicles Seminal emission Nocturnal emission Low sexual energy

__Prostate problems

Women Only

____Age of first period____Days between cycles____Days of flow

__Abnormal pap smear Bleed between periods Irregular periods Painful periods Heavy periods Scanty periods

__Clotting Breast tenderness Endometriosis Premenstrual tension Breast lumps

__Contraceptives (Type_____) Sores on genitalia Low sexual energy Vaginal discharges Yeast infections

__May be pregnant Uterine prolapse Facial hair Loss of head hair

__Menopause (Hot flashes Night sweats Emotional)