

New Patient Intake Form

Lisa Ledbetter, L. Ac.
Live Well / Natural Healing Acupuncture
3900 S. Wadsworth Blvd Suite #400
Lakewood CO 80235
303-934-3753

Name (Last, First, M) _____
Social Security (for Insurance) ____ - ____ - ____ Sex ____ Date of Birth _____
Height _____ Weight _____
Address _____
City _____ State _____ Zip Code _____
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. 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 of passage of board exam)
Licensed Acupuncturist with the State of Colorado, 1999-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), injection therapy, and advice about diet and lifestyle.

Statement of Ethics

- a) Lisa Ledbetter, L.Ac. Dipl.Ac. complies with all rules and regulations specified by the Colorado Dept 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 professional 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 \$99.00 (originally \$125)
- Follow up visit(s) \$85.00 (may include cupping, gua sha and herbal muscle testing)
- Children (under 12) \$60 first visit, \$40 follow up visits(s)
- Prepayment of 5 or more treatments Save \$25.00
- Herbal muscle testing only \$25 - 15 minute appt
- B12 shots \$30
- Arnica / Traumeel injections \$40
- Microneedling/Facial Rejuvenation \$250.00

*Chinese Herbal Medicines and supplements 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 at 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.

_____ Date _____
Signature

HIPAA Privacy Policies and Injection/Intradermal Therapy Consent

Please visit the Forms section of the <https://naturalhealthacupuncture.com> website to read the HIPAA Privacy Policies and Informed Consent injection/instradermals 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 ready a copy of the HIPAA Notice of Privacy Practices that are posited to the website.

Print Patient name or Personal Representative

_____ Date _____
Patient or Personal Representative Signature

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

Informed Consent Injections/Instradermals Therapy (B12 and Arnica injections)

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 expect my practitioner to be able to anticipate all risks and complications. I have read and understand the informed Consent injection/instradermals 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)

Patient Medical History

Lisa Ledbetter, L. Ac.
Live Well / Natural Healing Acupuncture
3900 S. Wadsworth Blvd Suite #400
Lakewood CO 80235
303-934-3753

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? None - __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 Drug Addiction Alcohol abuse Seizures

Major Surgeries: (Date/Description)

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

Current Medications:

Dose:

Times/Day:

<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>

Current Herbs, Vitamins and Supplements:

Dose:

Times/Day:

<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>

What do you eat/drink in a typical day?

Breakfast

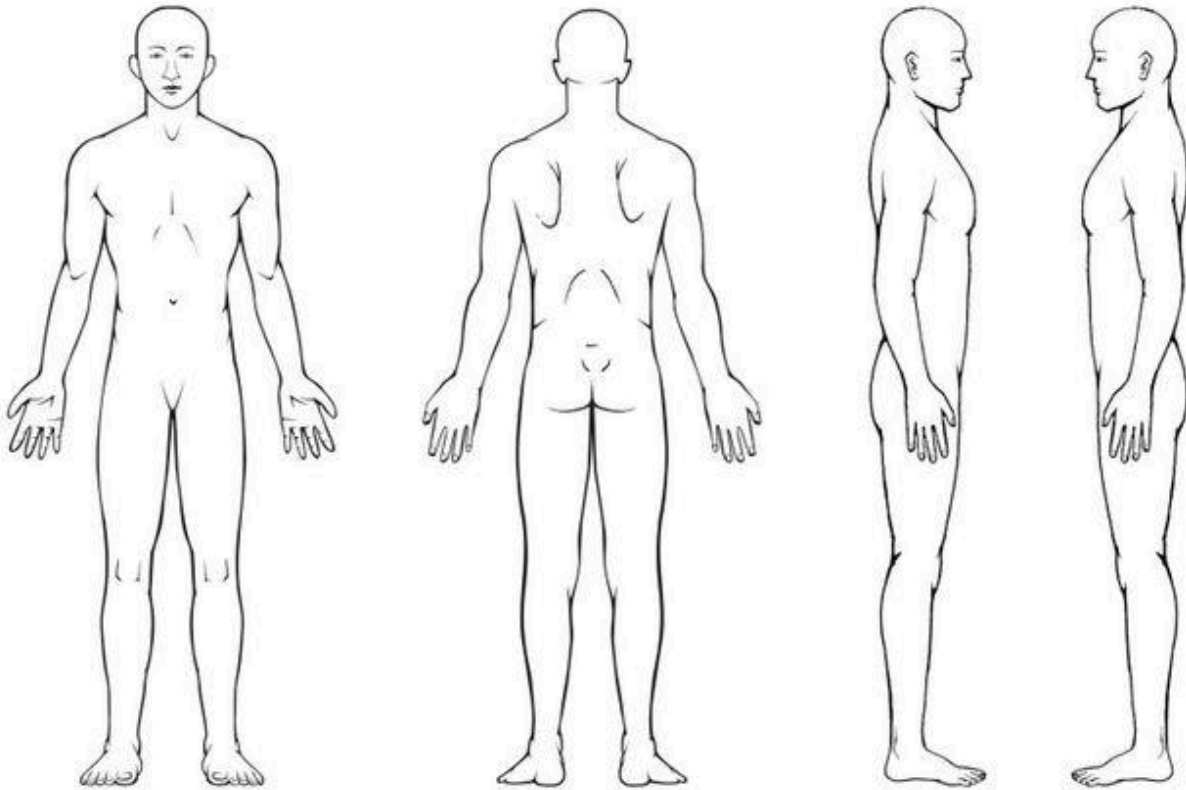
Lunch

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) THC Use (days/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 spasm

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 or 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

General 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 PCOS Cysts/fibroids
 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 genitals Low sexual energy Vaginal discharges
 Yeast infections May be pregnant Uterine prolapse Facial hair Loss of head hair
 Menopause (Hot flashes Night sweats Emotional)