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 house 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) $99 first visit, $60 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

_____ _____
Patient or Personal Representative Signature Date

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.
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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:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

What do you eat/drink in a typical day?

Breakfast

_____
_____

Lunch

_____
_____

Dinner

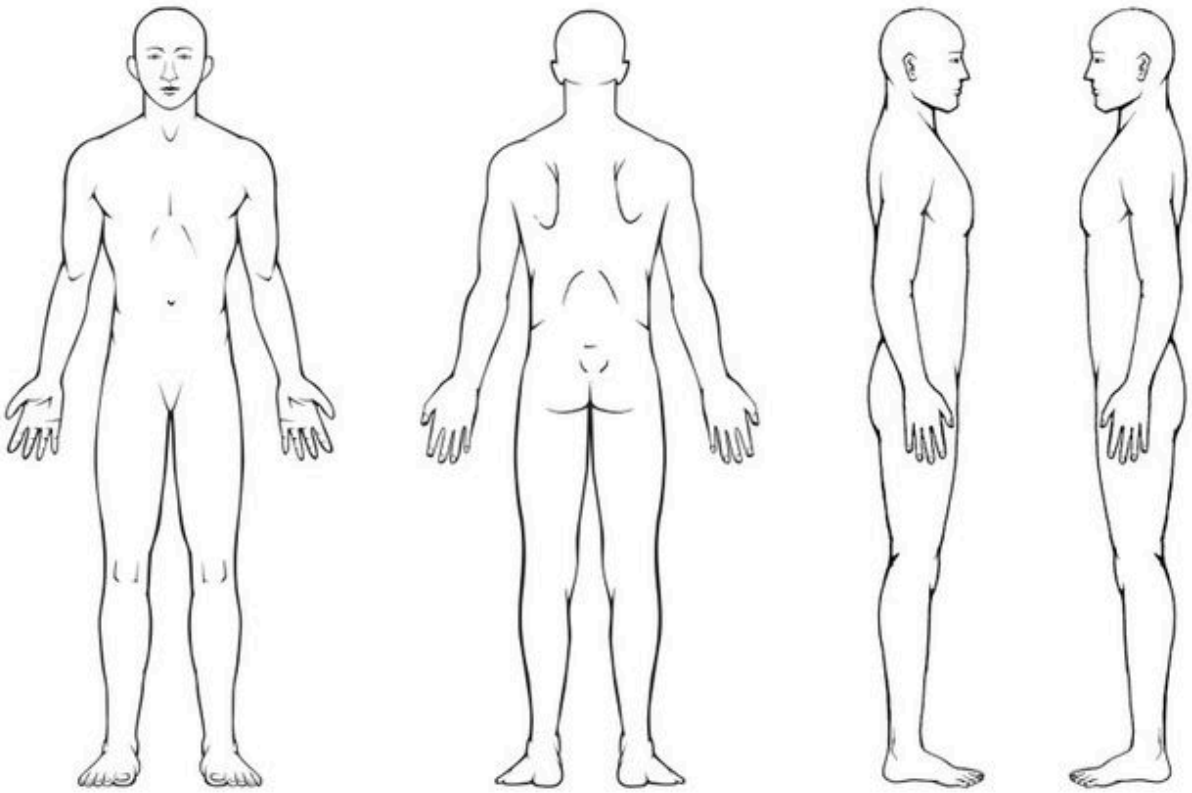
_____
_____

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) ___ THC Use (___ days/week)
___ Drink Coffee (___ cups/day) ___Crave sweats ___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
___Constraceptives (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)