M. Jennifer Lara Wright
BSN, DOM, Lac, Dipl. Of Ac, CH (NCCAOM)

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MANDATORY DISCLOSURE STATEMENT

FEE SCHEDULE		
	Initial Exam, Consultation, and Treatment	$150
	Follow-up Treatments	$105
	Additional ½ hour	$45

EDUCATION, DEGREES, EXPERIENCE, PROFESSIONAL MEMBERSHIPS, & CERTIFICATES

- **Northern Michigan University**, Marquette, MI - **Bachelor of Science in Nursing** - April 1995
- Certified in **Clean Needle Technique** - Council of Colleges of Acupuncture and Oriental Medicine (CCAOM) - Jan 1999
- International Institute of Chinese Medicine, Santa Fe, NM - **Master of Oriental Medicine** - May 1999
- 4 year study including study tour to China (Chengdu University of Traditional Chinese Medicine)
- Total curriculum of 2400 hours and includes more than 900 practice hours spent in observation, hands-on experience, and actual treatments
- Certified **Diplomat in Acupuncture and Chinese Medicine (Herbology)** by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) - January 2000
- Board Certified **Doctor of Oriental Medicine (DOM)** by the State of New Mexico - February 2000
- Licensed and Insured to practice in the State of Colorado - **LAc** – 1999 to present

STATEMENT OF TRAINING AND EXPERIENCE IN ADJUNCTIVE TRADITIONAL ORIENTAL THERAPIES

This practitioner's training and experience in the recommendation and application of adjunctive therapies and herbs as defined by traditional oriental medical concepts was encompassed in the Masters of Oriental Medicine degree. Such training and clinical experience included acupuncture, moxibustion, electrical stimulation, cupping, auriculotherapy, herbology, nutritional, diet, and supplementation therapy.

STATEMENT OF PRACTITIONER COMPLYING WITH PROPER RULES AND REGULATIONS

This practitioner is aware of and complies with the rules and regulations promulgated by the Department of Health with respect to proper cleaning and sterilization of needles - single use disposable needles are used in this practice of acupuncture and the sanitation of acupuncture offices.

This practice of Acupuncture and Oriental Medicine is regulated by the Colorado Department of Regulatory Agencies. Should you have any comments, complaints, or questions, you may contact them at the following address:

1550 Broadway, Suite 1545
Denver, Colorado 80202
(303) 894-2464

STATEMENT OF PATIENT RIGHTS

As a patient, you are entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known.

As a patient, you are entitled to seek a second opinion from another health care professional and may terminate therapy at any time.

This is 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.

CANCELLATION POLICY

An appointment has been reserved for you and someone else may have been denied the opportunity for service because of our agreed commitment. ***Thus, there will be a charge for missed appointments without a 12 hour notice.*** Keeping scheduled appointments helps me give you the quality of care and results that Traditional Chinese Medicine is known for.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION

______________________________ Patient or Guardian's Signature

______________________________ Date

Jennifer Wright
DOM, Lac, Dipl Ac., CH (NCCAOM)

NEW PATIENT FORM

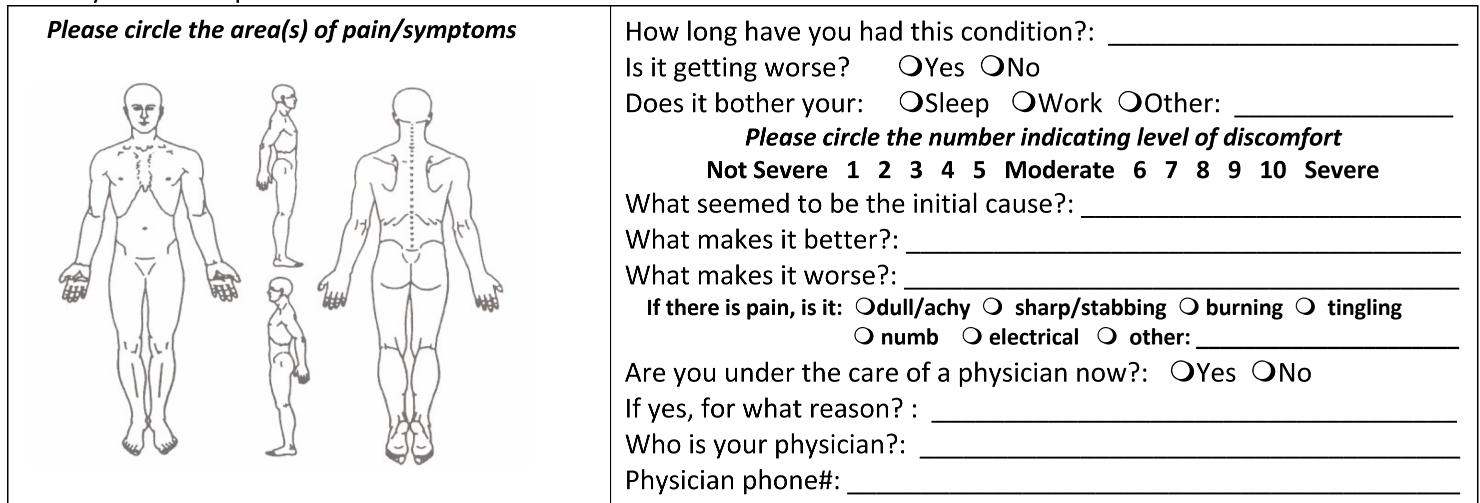
Confidential

2500 Youngfield St., Suite 4
Lakewood, CO 80215
303-475-8522

Date:	First Name:	Last Name:	
Date of Birth:	Age:	Occupation:	
Home Phone:	Work or Cell#:	Email:	
Street Address	City:	State:	Zip:
Emergency Contact (Name and phone)		Referred by:	

Reason for visit today: ____

Have you had acupuncture before?: ❍Yes ❍No Chinese Herbal Medicine?: ❍Yes ❍No



Please circle the area(s) of pain/symptoms

How long have you had this condition?: ____________________

Is it getting worse? ❍Yes ❍No

Does it bother your: ❍Sleep ❍Work ❍Other: ____________

Please circle the number indicating level of discomfort

Not Severe 1 2 3 4 5 Moderate 6 7 8 9 10 Severe

What seemed to be the initial cause?: ____________________

What makes it better?: ____________________

What makes it worse?: ____________________

If there is pain, is it: ❍dull/achy ❍ sharp/stabbing ❍ burning ❍ tingling ❍ numb ❍ electrical ❍ other: ____________

Are you under the care of a physician now?: ❍Yes ❍No

If yes, for what reason? : ____________________

Who is your physician?: ____________________

Physician phone#: ____________________

Are there other therapies that you are currently undergoing?: ____________________

SYMPTOMS:

LUNG/LARGE INTESTINE

____ Dry Cough
____ Cough with Sputum
____ Nasal Discharge
____ Post-Nasal Drip
____ 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 which Comes and Goes
____ Smoke Cigarettes
____ Metallic Taste in Mouth
____ Lung Disease

Other symptoms:

____ Fever Chills
____ Food Cravings (please specify):
____
____ Poor Balance

STOMACH/SPLEEN

____ Heaviness Anywhere in Body
____ Fatigue/Worse after Eating
____ Hard to Get Up in the Morning
____ Edema (Swelling)
____ Muscles Feel Tired Often
____ Easily Bruise or Bleed
____ Bad Breath
____ Decreased Increased Appetite
____ Crave Sweets
____ Hypoglycemia
____ Difficulty Digesting Oily Foods
____ Nausea/Vomiting
____ Gas/Belching
____ Insulin Sensitivity
____ Hemorrhoids
____ Constipation
____ Diarrhea
____ Abdominal Pain
____ Indigestion/Heartburn
____ Over-thinking
____ Tendency to Gain Weight
____ Brain Fog/Lack of Concentration
____ Light headedness

HEART/SMALL INTESTINES

____ Heart Palpitations
____ Chest Pain
____ Insomnia/Sleep Problems
____ Easily Startled
____ Restlessness/Agitation
____ Vivid Dreams
____ Lack of Joy in Life
____ Mouth Sores

KIDNEY/URINARY BLADDER

____ Urinary or Bladder Problems/Infections
____ Lack of Bladder Control
____ Weakness/Pain in Lower Back
____ Decrease Bone Density
____ Feel Cold Easily
____ Low Sex Drive ____ Excess Sexual Desire
____ Poor Memory
____ Loss of Hair
____ Hearing Problems
____ Cavities
____ Craving/Avoiding Salty Foods
____ Fear
____ Hot Flush/Night Sweats

LIVER/GALLBLADDER

____ Irritability/Anger
___ Depression/Stress
____ Headaches/Migraines
____ Visual Problems
____ Red/Dry/Itchy Eyes
____ Gall Stones
____ Dizziness
____ Blurred Vision
____ Feeling a lump in Throat
____ Clenching of Teeth at Night
____ Muscle Cramping/Twitching
____ Tension
____ Joints/Neck/Shoulder Pain/Tight
____ Poor Circulation
____ Soft/Brittle Nails
____ Emotional Eater
____ Sighing
____ Bitter Taste in Mouth

YOUR MEDICAL HISTORY

____ AIDS/HIV
____ Alcoholism
____ Allergies
____ Anorexia
____ Appendicitis
____ Arthritis
____ Asthma
____ Breast Lumps
____ Cancer
____ Chronic Fatigue
____ Diabetes
____ Emphysema
____ Epilepsy
____ Fibromyalgia
____ Goiter
____ Gout
____ Heart Disease
____ Hepatitis
____ Herpes
____ High Cholesterol
____ High Blood Pressure
____ Measles
____ Mononucleosis
____ Pacemaker
____ Pleurisy
____ Pneumonia
____ Polio
____ Rheumatism
____ Scarlet Fever
____ Seizures
____ Strokes
____ Surgery: (please list)________________
____
____ Thyroid Disorder
____ Major Trauma (Car, fall, accident, etc.
____
____ Other (please specify)_______________
____

Do you have any ALLERGIES? ____

MEDICATIONS*:* Please list any medications you have taken within the last two (2) months. Include vitamins, OTC drugs, herbs, alcohol, marijuana, etc.:____

OCCUPATION*:* Do you usually work ❍ indoors ❍ outdoors?
Are there any occupational stressors (chemical, physical, psychological)? ________________________________

NUTRITION*:*
Do you drink caffeinated beverages? ❍ Yes ❍ No If so, how many per day? ______________________
Do you drink alcoholic beverages? ❍ Yes ❍ No If so, how many per week? ______________________
How much water do you drink per day? ______________________

Please describe your average daily diet (please be as specific as possible):

Morning:

Afternoon:

Evening:

Snacks:

WOMEN ONLY:
When was your last period? ______________________
How long does your cycle last? ______________________
Number of days for monthly cycle? ______________________
Describe menstrual flow: ❍ Heavy ❍ Moderate ❍ Light ❍ None
Color of menstrual flow: ❍ Dark ❍ Bright Red ❍ Slightly Reddish
Birth Control: ❍None ❍ IUD ❍ Pill ❍ Spermicidal ❍ Barriers

Do you suffer from:
❍ Cramping: ❍ Severe ❍ Mild ❍ During Period ❍ Moderate ❍ Before Period ❍ After Period
❍ Clotting ❍ Bleeding between periods
❍ Pelvic Inflammatory Disease ❍ Endometriosis
❍ Mastitis ❍ PMS
❍ Yeast or other Vaginal Infections: ______________________
❍ Infertility Cysts: ❍ Breast ❍ Ovarian

MEN ONLY:
❍ Do you suffer from:
❍ Impotence
❍ Weak Erection
❍ Discharge from Penis
❍ Testicular Pain or Lump
❍ Premature Ejaculation
❍ Prostate Problems: PSA: ______________
❍ Infertility
❍ Low Sex Drive