

Jessica DePete, M.S., L.Ac.  
Wellspring East, 243 East Brown Street, East Stroudsburg, PA 18301  
570-801-1369

<b>Name:</b> _____ Address: _____ _____ _____ Email: _____ Date of Birth: _____	<b>Date:</b> _____ Home Phone: _____ Mobile Phone: _____ Texting OK? Y N Work Phone: _____ <i>(Please indicate your preferred method of contact).</i> Occupation: _____
What is your primary reason for coming for acupuncture? _____ When did you become aware of it? _____ Was onset sudden or gradual? _____ Symptoms are relieved by _____ and worsened by _____ Are there other symptoms you would like to address with acupuncture? Please list: _____ _____ _____	
What medical diagnoses have you received? _____ What other treatments have you received? _____	
Name of physician: _____ City/State _____ Phone _____ When was your most recent physical examination? _____	
Have you had acupuncture before? _____ How did you hear about my acupuncture practice? _____	

<b><u>Diet/Appetite/Thirst</u></b> How is your appetite? _____ What does your typical diet consist of? _____ _____ Do you have intolerance to any foods or any dietary restrictions? _____ Do you take any supplements or vitamins? Please list. _____ _____ Are you often thirsty? _____ Do you prefer <b>HOT</b> or <b>COLD</b> drinks? _____
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<b><u>Lifestyle</u></b> What do you do for pleasure? _____ _____ Are you <b>SINGLE</b> <b>MARRIED/STABLE RELATIONSHIP</b> <b>OTHER</b> _____ How is your sexual energy? _____ Do you smoke cigarettes? _____ How many per day? _____ For how long? _____ Do you use any recreational drugs (including alcohol)? _____ Do you exercise? _____ Please describe: _____
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<b><u>Energy/Exercise/Temperature</u></b> How is your energy? _____ At what time of day is your energy highest? _____ Lowest? _____ Do you fatigue easily? If yes, what activities most fatigue you? _____ Do you often feel unusually hot or cold? _____ Do you have chills or fever? _____ Do you have any unusual sweating? _____
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**Emotions/Sleep**

How do you feel emotionally? Are you satisfied with your emotional state? \_\_\_\_\_

\_\_\_\_\_

How many hours per night do you normally sleep? \_\_\_\_\_ Does this feel like enough? \_\_\_\_\_

How is the quality of your sleep (e.g. restless, restful, etc.)? \_\_\_\_\_

Do you feel rested upon awaking? \_\_\_\_\_ Do you nap during the day? \_\_\_\_\_

**Women**

At what age did you start menstruating? \_\_\_\_\_ # Days in a typical cycle: \_\_\_\_\_ # Days of flow: \_\_\_\_\_

Color of flow (bright red, rusty, etc.): \_\_\_\_\_ Clots? \_\_\_\_\_ Date of last period: \_\_\_\_\_

Any vaginal discharge? \_\_\_\_\_ Describe (Amount, color, frequency, etc.) \_\_\_\_\_

PMS symptoms \_\_\_\_\_

Are your symptoms worse prior to, during, or after flow begins? \_\_\_\_\_

If you are menopausal or post-menopausal, please describe symptoms: \_\_\_\_\_

Number of pregnancies: \_\_\_\_\_ Number of deliveries: \_\_\_\_\_ Ages of children: \_\_\_\_\_

**Are you pregnant, or currently trying to get pregnant?** \_\_\_\_\_

**Medical History**

Please describe any significant events in your medical history (hospitalizations, accidents, etc.): \_\_\_\_\_

\_\_\_\_\_

Please list all medications you take (or have taken regularly in the past): \_\_\_\_\_

\_\_\_\_\_

<b>Please describe any that apply in:</b>	<b>Your own history:</b>	<b>Your family's history:</b>
Cardiovascular disorders		
Cancer		
Hypertension		
Thyroid disorder		
Hepatitis		
Tuberculosis		
HIV/AIDS		
STDs		
Congenital disorders		
Seizures		
Stroke		
Neurological disorders		
Psychological disorders		
Gastrointestinal disorders		
Urinary/Bladder disorders		
Gynecological disorders		
Pain disorders		
Respiratory disorders		
Headaches/Migraines		
Ears/Eyes/Nose/Throat disorders		
Skin/Hair disorders		

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## *INFORMED CONSENT*

I hereby consent to be treated by Jessica DePete, M.S., L.Ac., with acupuncture and/or other Oriental medicine procedures, which may include acupuncture, moxibustion, cupping, gua sha, electrical stimulation, tui-na (Chinese massage), Chinese herbal medicine, or nutritional and lifestyle counseling.

- ☉ I understand that acupuncture is performed by the insertion of pre-sterilized acupuncture needles through the skin, with or without the addition of heat or electrical stimulation, to certain points on the body, with the intent of improving bodily functions, relieving pain, and treating certain diseases or bodily dysfunction.
- ☉ I have been informed that acupuncture, when performed by qualified licensed practitioners, is a safe method of treatment, but in rare occasions side effects may occur. The most common of these are bruising or tingling near the needling sites for a few days, fatigue, or temporary aggravation of pre-existing symptoms. Other possible, though extremely rare, side effects include fainting, spontaneous miscarriage or pneumothorax. If I experience any symptom I believe may be the result of an acupuncture treatment, I have been advised to contact my acupuncturist promptly for guidance.
- ☉ I understand that I should also inform my acupuncturist prior to being treated if I believe that I might be pregnant or am trying to become pregnant.
- ☉ I accept the fact that no guarantee is made concerning the outcome of my acupuncture or herbal medicine treatments and that I may stop treatment at any time.
- ☉ I understand that it is not within the scope of practice for acupuncturists to offer Western medical (biomedical) diagnosis and that it is my responsibility to seek such diagnosis elsewhere if I have not already done so.

x \_\_\_\_\_  
Patient's name (please print)

x \_\_\_\_\_  
Patient's signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
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**From Route 80 West:**

Take Exit 308 towards East Stroudsburg. At the end of the exit ramp, make a right onto Prospect Street. At the first traffic light, make a right onto East Brown Street. You will pass Pocono Medical Center and the East Stroudsburg University playing fields on the left. Wellspring East is on the right, #243 East Brown Street. Our office is on the first floor.

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