

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

Name: _____ Address: _____ _____ _____ Email: _____ Date of Birth: _____	Date: _____ 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? _____	

<u>Diet/Appetite/Thirst</u> 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 HOT or COLD drinks? _____
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<u>Lifestyle</u> What do you do for pleasure? _____ _____ Are you SINGLE MARRIED/STABLE RELATIONSHIP OTHER _____ 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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<u>Energy/Exercise/Temperature</u> 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): _____

Please describe any that apply in:	Your own history:	Your family's history:
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		