free flow acupuncture

Jessica DePete, MS, Lac

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570.801.1369
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Name: _____ **Date:** _____
Address: _____ Home Phone: _____
_____ Mobile Phone: _____ Texting OK? Y N
_____ Email: _____
Date of Birth: _____ 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? _____

Diet/Appetite/Thirst

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? _____

Lifestyle

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: _____

Energy/Exercise/Temperature

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		
High/low blood pressure		
Thyroid disorder		
Hepatitis		
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		

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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

_____
Jessica DePete, M.S., L.Ac.