Acupuncture Care

Candice C. Ellis LiAc (diplomate) NCCAOM
100 Cummings Center #321J
Beverly, MA 01915
Phone 978-969-0252 · Fax 979-969-0356
e-mail care@acucandice.com

Please print your name here _____ Today's Date _____

If you have any of the following symptoms, check the box that tells us if the symptom was in the past or if it is current. Also, circle one of the numbers that appears to the right of the symptom. Circle 1 for the least severe and 5 for the most severe.

Past	Current						
☐	☐	Abdominal/stomach pain	1	2	3	4	5
☐	☐	Always Hungry	1	2	3	4	5
☐	☐	Black Stools	1	2	3	4	5
☐	☐	Constipation (less than 1 daily bowel movement)	1	2	3	4	5
☐	☐	Diarrhea	1	2	3	4	5
☐	☐	Heartburn	1	2	3	4	5
☐	☐	Indigestion	1	2	3	4	5
☐	☐	Gas	1	2	3	4	5
☐	☐	Lack of Appetite	1	2	3	4	5
☐	☐	Nausea	1	2	3	4	5
☐	☐	Overweight	1	2	3	4	5
☐	☐	Unusually Thirsty	1	2	3	4	5
☐	☐	Vomiting	1	2	3	4	5
☐	☐	Weight Changes	1	2	3	4	5
☐	☐	Bleeding Easily	1	2	3	4	5
☐	☐	Bleeding Gums	1	2	3	4	5
☐	☐	Bruising Easily	1	2	3	4	5
☐	☐	Chest Pain or Pressure	1	2	3	4	5
☐	☐	Dizzy Spells or Blackouts	1	2	3	4	5
☐	☐	Irregular Heart Beat	1	2	3	4	5
☐	☐	Racing Heart Beat	1	2	3	4	5
☐	☐	Chest Colds	1	2	3	4	5
☐	☐	Chronic Cough	1	2	3	4	5
☐	☐	Congested Nose	1	2	3	4	5
☐	☐	Coughing up Blood	1	2	3	4	5
☐	☐	Smoking	1	2	3	4	5
☐	☐	Sneezing	1	2	3	4	5
☐	☐	Wheezing	1	2	3	4	5
☐	☐	Chills	1	2	3	4	5
☐	☐	Excessive Sweating	1	2	3	4	5
☐	☐	Fever	1	2	3	4	5
☐	☐	Lack of Perspiration	1	2	3	4	5
☐	☐	Night Sweats	1	2	3	4	5
☐	☐	Tendency to be too cold	1	2	3	4	5
☐	☐	Tendency to be too hot	1	2	3	4	5
☐	☐	Pain (list other locations)					

_____

Past	Current						
☐	☐	Earaches	1	2	3	4	5
☐	☐	Frequent or Extended Hoarseness	1	2	3	4	5
☐	☐	Hearing Difficulties	1	2	3	4	5
☐	☐	Nosebleeds	1	2	3	4	5
☐	☐	Sinus Problems	1	2	3	4	5
☐	☐	Sore Throats	1	2	3	4	5
☐	☐	Sounds/RInging in Ears	1	2	3	4	5
☐	☐	Swollen Glands	1	2	3	4	5
☐	☐	Trouble with Your Eyes	1	2	3	4	5
☐	☐	Unusual Taste in Mouth	1	2	3	4	5
☐	☐	Dry Skin	1	2	3	4	5
☐	☐	Itching or Burning Skin	1	2	3	4	5
☐	☐	Skin Rash	1	2	3	4	5
☐	☐	Bloody Urination	1	2	3	4	5
☐	☐	Burning Urination	1	2	3	4	5
☐	☐	Difficulty Urinating	1	2	3	4	5
☐	☐	Frequent Urination	1	2	3	4	5
☐	☐	Painful Urination	1	2	3	4	5
☐	☐	Urination at Night	1	2	3	4	5
☐	☐	Loss of Bladder Control	1	2	3	4	5
☐	☐	Convulsions	1	2	3	4	5
☐	☐	Depression	1	2	3	4	5
☐	☐	Fatigue or Tiredness	1	2	3	4	5
☐	☐	Frequent or Severe Headache	1	2	3	4	5
☐	☐	Difficulty Getting to Sleep	1	2	3	4	5
☐	☐	Difficulty Staying Asleep	1	2	3	4	5
☐	☐	Leg Cramps	1	2	3	4	5
☐	☐	Nervousness	1	2	3	4	5
☐	☐	Numbness or Tingling	1	2	3	4	5
☐	☐	Shaking or Trembling	1	2	3	4	5
☐	☐	Stuttering or Stammering	1	2	3	4	5
☐	☐	Back Trouble	1	2	3	4	5
☐	☐	Pain or Swelling — Any Joint	1	2	3	4	5
☐	☐	Painful Feet	1	2	3	4	5
☐	☐	Painful Muscles	1	2	3	4	5
☐	☐	Stiff or Painful Neck	1	2	3	4	5
☐	☐	Swelling of Feet or Legs	1	2	3	4	5
☐	☐	Other Symptoms:					

_____

Please check if you have ever had any of the following:

Past	Current	
☐	☐	HIV
☐	☐	Acid Reflux
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Arthritis
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Bone Disease
☐	☐	Bronchitis
☐	☐	Bursitis
☐	☐	Cancer or Tumor
☐	☐	Chicken Pox
☐	☐	Colon/Bowel Disease
☐	☐	Diabetes
☐	☐	Diphtheria
☐	☐	Drug Habit

Past	Current	
☐	☐	Osteoporosis
☐	☐	Drug sensitivity or reaction
☐	☐	Emotional or mental problems
☐	☐	Emphysema
☐	☐	Gall Stones
☐	☐	Gall Bladder Problems
☐	☐	German Measles
☐	☐	Heart Trouble
☐	☐	Heart Murmur
☐	☐	Hemorrhoids
☐	☐	Hepatitis/Jaundice
☐	☐	Herpes
☐	☐	High Blood Pressure
☐	☐	Hives

Past	Current	
☐	☐	Kidney Stones
☐	☐	Kidney or Bladder Infection
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Lupus
☐	☐	Malaria
☐	☐	Measles
☐	☐	Mononucleosis
☐	☐	Mumps
☐	☐	Pancreatitis
☐	☐	Pleurisy
☐	☐	Pneumonia
☐	☐	Polio

Past	Current	
☐	☐	Rheumatic Fever
☐	☐	Scarlet Fever
☐	☐	Spinal Meningitis
☐	☐	Stomach or Duodenal Ulcer
☐	☐	Tendonitis
☐	☐	Tuberculosis
☐	☐	Thyroid or Goiter Trouble
☐	☐	Typhoid
☐	☐	Venereal Disease
☐	☐	Varicose Veins
☐	☐	Whooping Cough

☐ ☐ Other specific illnesses you have had:

Please list all surgeries & hospitalizations you've had

Please list all accidents, injuries, broken bones, etc.

List all current medicines, even ones seldom uses

Check if you have family history of any of these:

☐	☐	AIDS
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Arthritis
☐	☐	Cancer
☐	☐	Diabetes
☐	☐	Epilepsy
☐	☐	Glaucoma
☐	☐	Gout
☐	☐	Heart Disease
☐	☐	High Blood Pressure
☐	☐	Mental Illness
☐	☐	Problems with Alcohol
☐	☐	Stroke
☐	☐	Thyroid Disease
☐	☐	Other Potentially Inheritable Diseases

WOMEN: Please check if you have ever had any of the following:

Past	Current	
☐	☐	Abdominal pain or cramping with menstruation
☐	☐	Abnormal PAP smear
☐	☐	Abortion
☐	☐	Back pain with menstruation
☐	☐	Birth control pills
☐	☐	Bleeding between periods

Past	Current	
☐	☐	Bleeding during or after intercourse
☐	☐	Bleeding before periods
☐	☐	Blood discharge from nipples
☐	☐	Breast lumps
☐	☐	Heavy bleeding with periods

Past	Current	
☐	☐	Hot flashes
☐	☐	Irregular periods
☐	☐	I.U.D.
☐	☐	Menopause
☐	☐	Miscarriage
☐	☐	Premenstrual tension / syndrome
☐	☐	Pregnancy

Past	Current	
☐	☐	Scanty bleeding with periods
☐	☐	Tubal ligation
☐	☐	Sickness/weakness with periods
☐	☐	Vaginal discharge
☐	☐	Vaginal dryness or itching

Duration of Menstrual Periods:

Interval between periods:

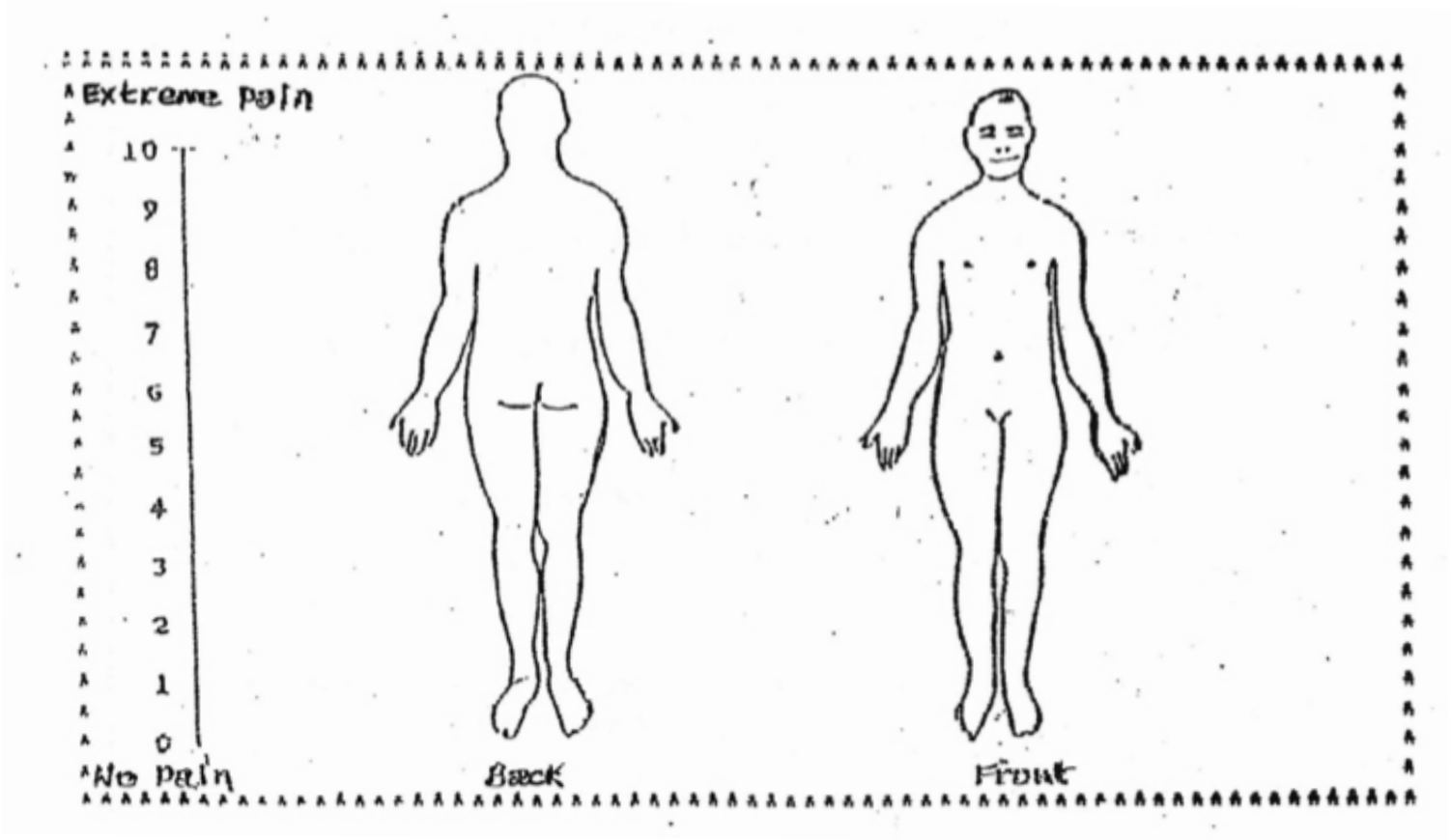
Date of last period:

Number of births you have had

Ages of your children

Birth control method you use

Pain Assessment



Type of work _____

Type of physical activity that affects your pain _____

PLEASE INDICATE THE AREA OF YOUR CONDITION IN THE FIGURES ABOVE. THEN MARK THE SEVERITY OF YOUR DISCOMFORT ON THE SCALE OF 0–10.

Signature _____ Date _____