ACUPUNCTURE CARE

100 Cummings Center
Suite # 321J
Beverly, MA 01915

Candice C. Ellis Lic Ac NCCAOM

Name: _____ Date: _____/_____/_____

Address: _____City: _____ State: _____ Zip: _____

Phone: Primary ( ) _____ Other ( ) _____ Work ( )_____

E-mail: _____ (optional)

Would you like a monthly statement? Y ( ) N ( )

Type of Work: _____ Can you be called at work? Y ( ) N ( )

Date of Birth: _____/_____/_____ Sex: F ( ) M ( )

Referred By: _____ Family/Personal M.D.:_____

In Case of Emergency
Please notify: _____ Phone#: ( ) _____

Have you been injured in an accident? (work) or (auto) _____
If yes, date of accident: _____

Name of Health
Insurance:_____Subscriber:_____

Main Health Concern: _____
_____

All Medications/Vitamins/Supplements you currently take: _____
_____ _____
_____ _____
_____ _____
_____ _____

Previous Acupuncture: Yes ( ) No ( )
If yes, Conditions treated & Results: _____

Comments:_____
_____
_____