OLSON ACUPUNCTURE & NUTRITIONAL HEALING

acupuncture | herbal medicine | nutrition therapy

Please print clearly

Name_____ Todays Date _____

Date of Birth _____ Age _____ Height _____ Weight _____ Gender_____

Address_____

City _____ State _____ ZIP _____

Primary Phone (____) ____-_____ type: _____ Secondary Phone (____) ____-_____

e-mail address: _____@_____

Occupation_____Relationship Status: S R M D W

Emergency Contact: _____ Phone: _____

Referred By:_____

Overall health (circle one): Good / Fair / Poor

Primary complaint: _____

Other complaints or problems:

_____

_____

Optional: List any other doctors/therapists/specialists that have treated this complaint:

Name:_____Location:_____

Name:_____Location:_____

Name:_____Location:_____

Medical History

Anxiety	*Current* ❑ *Past* ❑	Digestive Issues	*Current* ❑ *Past* ❑	Asthma	*Current* ❑ *Past* ❑
Depression	*Current* ❑ *Past* ❑	Crohn's	*Current* ❑ *Past* ❑	Sinus Issues	*Current* ❑ *Past* ❑
Stress	*Current* ❑ *Past* ❑	Colitis	*Current* ❑ *Past* ❑	COVID	*Current* ❑ *Past* ❑
Insomnia	*Current* ❑ *Past* ❑	IBS	*Current* ❑ *Past* ❑	Lyme Disease	*Current* ❑ *Past* ❑
TMJ	*Current* ❑ *Past* ❑	Constipation	*Current* ❑ *Past* ❑	Fibromyalgia	*Current* ❑ *Past* ❑
Headache	*Current* ❑ *Past* ❑	Diarrhea	*Current* ❑ *Past* ❑	Autoimmune	*Current* ❑ *Past* ❑
Eating Disorder	*Current* ❑ *Past* ❑	GERD	*Current* ❑ *Past* ❑	Chronic Fatigue	*Current* ❑ *Past* ❑
Seizures	*Current* ❑ *Past* ❑	Ulcers	*Current* ❑ *Past* ❑	M.S.	*Current* ❑ *Past* ❑
Hypertension	*Current* ❑ *Past* ❑	Hepatitis	*Current* ❑ *Past* ❑	HIV/AIDS	*Current* ❑ *Past* ❑
High Cholesterol	*Current* ❑ *Past* ❑	Joint Pain	*Current* ❑ *Past* ❑	Stroke	*Current* ❑ *Past* ❑
Thyroid	*Current* ❑ *Past* ❑	Arthritis	*Current* ❑ *Past* ❑	Heart Attack	*Current* ❑ *Past* ❑
Diabetes	*Current* ❑ *Past* ❑	Back Issues	*Current* ❑ *Past* ❑	Heart Disease	*Current* ❑ *Past* ❑
Cancer	*Current* ❑ *Past* ❑	Cancer Type:_____			

Medical conditions not previously listed:

_____

_____

_____

_____

_____

Current medications/nutritional supplements being taken:

_____

_____

_____

_____

_____

Allergies/Sensitivities:

_____

_____

_____

If using, indicate how much:

Nicotine _____ Coffee _____Soda_____Alcohol _____CBD/THC_____

Signed: _____ Date: _____

Acknowledging Receipt of Notice on Privacy Policy

I have read, reviewed, understand and agree to the statement of the Privacy Policy for healthcare service of this office. Following HIPPA guidelines, this practice has attempted to provide each patient with a statement of the Privacy Policy.

Signature:_____Date: _____