OLSON ACUPUNCTURE GROUP

New Patient Information Form

(Please print clearly)

Name_____ Todays Date _____

Address_____

City _____ State _____ ZIP _____

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

e-mail address: _____

Occupation _____ Marital Status _____ _____

Date of Birth_____Age ____ Height _____ Weight _____

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

Primary complaint: _____

Other complaints or problems: _____

_____

Medical History – Please mark conditions you have / have had

Anxiety ___ Depression ___ Stress ___ TMJ ___ Ulcers ___ Headache ___ Insomnia ___
Digestive Issues ___ Colitis ___ Crohns ___ Irritable Bowel ___ Constipation ___Diarrhea ___
Asthma ___ Cough ___ Sinus Issues ___ Dizziness ___ Night Sweats ___ Memory Loss ___
Back Issues ___ Joint Pain ___ Arthritis ___ Fibromyalgia ___Multiple Sclerosis ___Fatigue ___
High Cholesterol ___ Thyroid Disease ___Hypertension ___ Heart Disease ___ Heart Attack ___
Frequent Urination ___ Bladder Disease ___ Kidney Disease ___ Menstrual Issues ___
Stroke ___Cancer ___ Prostate ___ Hepatitis A B C D ___ HIV/AIDS ___ Seizure ___ Diabetes ___

Surgeries/ Conditions not listed above:

_____

_____

_____

Current medications/nutritional supplements being taken:

_____

_____

_____

_____

Allergies/Sensitivities: _____

_____

Household pets or other animals you are in close contact with:

_____

_____

_____

Do you smoke, drink coffee, soda or alcohol? (if yes indicate how much)
Cigarettes _____ Coffee _____ Soda_____Alcohol _____

Emergency Contact: _____ Phone: _____

Referred By:_____

Signed: _____ Date: _____