

HOLLY JOHANTGEN, D.O.M, A.P.
Doctor of Oriental Medicine
Primary Care Physician



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Name _____ Date of Birth: _____
Phone(home) _____ (work) _____ (cell) _____
Address _____ City _____ State _____ Zip Code _____
Email _____ Referred by _____
Occupation _____ Marital Status _____
Emergency Notification _____
Main Concerns _____ Onset _____

Past Medical History (include dates):

Surgeries: _____

Significant Traumas (auto accidents, falls, etc.): _____

Allergies (food, drug, chemical): _____

Pregnancies (births, miscarriages, abortions, etc.): _____

Cancer _____ Diabetes _____ Heart Disease _____ High Blood Pressure _____

Hepatitis _____ Rheumatic Fever _____ Seizures _____ Thyroid Disease _____

Venereal Disease _____ HIV/AIDS _____ Candida _____ Other _____

Exposure to environmental contaminants: _____

Habits: Cigarettes _____ Coffee _____ Tea _____ Cola _____ Alcohol _____ Drugs _____

Other _____

Family Medical History:

Cancer _____ Diabetes _____ High Blood Pressure _____ Heart Disease _____

Stroke _____ Seizures _____ Asthma _____ Allergies _____ Alcoholism _____

Other _____

Physicians: _____

Acupuncture Consent Form: I hereby voluntarily agree to accept acupuncture treatments, and I am aware of the possible responses, such as bruising at the sight of needle insertion, that may occur as a result of this procedure. I also understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.

Signature: _____ Date: _____

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