# OLSON ACUPUNCTURE GROUP
## Nutrition Response Testing™ Intake Form

**Please Print Clearly:**

Name _____ Date _____

Address _____ Apt. # _____

City _____ State _____ ZIP _____

Primary Phone _____ Secondary Phone _____

Date of Birth _____ Age ____ Sex: M/F Height _____ Weight _____

Occupation _____ Marital Status: S M D W

Email Address _____

**REFERRED BY:** _____

List your main health concern: _____

_____

_____

Current medications being taken: _____

_____

_____

Nutritional supplements being taken: _____

_____

Food sensitivities: _____

Do you smoke or drink coffee or alcohol? (If yes indicate how much):
Cigarettes _____ Coffee _____ Alcohol _____

**SIGNED** _____ **DATE** _____