



Backyard Healthcare Project
204 E. Fort Lowell Rd.
Tucson AZ 85705
(520) 867-8004
www.acupuncturecoop.com

Registration Form / Health History Questionnaire

LEGAL NAME _____ PREFERRED NAME _____

ADDRESS _____
STREET APT# CITY STATE ZIP CODE

TELEPHONE # _____

EMAIL _____ WOULD YOU LIKE TO BE ON OUR MAILING LIST? YES NO

DATE OF BIRTH ____/____/____ WHAT IS YOUR GENDER? _____
PRONOUN(S): _____

HOW DID YOU LEARN ABOUT TUCSON ACUPUNCTURE CO-OP? _____

FIRST TIME GETTING ACUPUNCTURE? _____

OCCUPATION _____ COMPANY NAME _____

EMERGENCY CONTACT _____ RELATIONSHIP _____

TELEPHONE # _____

TODAY'S DATE ____/____/____

What are your primary reasons for coming in for treatment?

1. _____
2. _____
3. _____

How is your sleep? _____

How is your digestion? _____

Medications/Supplements you take: _____

Major Illnesses/Accidents/Surgeries: _____

Check those you have or have had this year:

Difficulty coping with stress and/or emotions

Depression/Anxiety

Major life events (i.e. move, job loss, relationship change)

Major change in overall health

Do you have access to primary medical care? _____

Do you want support in cutting back on any addictive habits? _____

Could you be pregnant? No Yes