TUCSON ACUPUNCTURE CO-OP

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 _____ _____
HOME WORK CELL

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

DATE OF BIRTH ____/_____/_____ FEMALE / MALE / TRANS (FTM/MTF)
PREFERRED PRONOUN: M / F/ OTHER_____

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

FIRST TIME GETTING ACUPUNCTURE? _____

OCCUPATION _____ COMPANY NAME_____

EMERGENCY CONTACT_____RELATIONSHIP_____

TELEPHONE _____ _____
HOME WORK CELL

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: _____
_____

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

Major Illnesses/Accidents/Surgeries: _____

Do you have access to primary medical care? _____

Could you be pregnant? □ No □ Yes

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

_____