Registration Form / Health History Questionnaire

Legal Name _____ Preferred Name _____

Address_____
Street Apt # City State Zip

Phone number_____
Home Work Cell

Email _____ Date of Birth _____/_____/_____

Female | Male | Trans* FTM | MTF Pronouns: HE | SHE | OTHER: _____

How did you learn about us? _____ First time getting acupuncture? YES | NO

Occupation _____ Company/org name_____

Emergency contact:_____
Name Relationship

Emergency contact phone:_____
Home Work Cell

Signature _____ DATE _____/_____/_____

What are your primary reasons for coming in for treatment?

1.

2.

3.

How is your sleep?_____

How is your digestion?_____

Check those you have or have had this year:

- ☐ Difficulty coping with stress or emotions
- ☐ Depression/Anxiety
- ☐ Major life events (i.e. move, job loss, relationship change)
- ☐ Major change in overall health

Medications/Supplements you take:
_____

Major Illnesses/Accidents/Surgeries:
_____

Do you exercise regularly?_____

Do you have access to primary medical care? _____

Do you want help cutting back on addictions? _____

Could you be pregnant?_____