ACUPUNCTURE 365 PLLC
HEMDA RAHMANI Dipl. L,A,c
NEW YORK BOAORD CERTIFIED ACUPUNCTURIST

CLIENT MEDICAL HISTORY

Today's Date:______________________________

First Name	Middle Name	Last Name
Date of birth	Street address	
City	state	zip
Contact phone	Email	
Occupation		

Gender: Male Female Height: __________ Weight ________________

Who's primary health care provider? ____________________ Phone: ____________

Main problem you would like us to help you with:

____

Name of physician that treated this problem? (Optional)

Have ever given diagnosis for this problem?

Are you currently receiving treatment for your problem? Please describe:

____

Illnesses:

____

surgeries: ____

Significant trauma or injuries; (car accident of fall, etc.):_____________________________

____

Medication: ___________________ reason for use:__________________________
Medication: ___________________ reason for use:__________________________
Medication: ___________________ reason for use:__________________________

Patient Name: __________________ Signature ______________________________