

**Eric M. Baron, M.S., L.Ac., Dipl.Ac.**

**Patient Health History**

Full Legal Name: \_\_\_\_\_ Date: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: M F Marital Status: \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Email Address: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Referred by or how did you hear about me: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

**Chief Complaint:**

Reason for visit: \_\_\_\_\_

When did this condition begin? \_\_\_\_\_

Describe symptoms you have now: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Please state diagnosis (if known): \_\_\_\_\_

What diagnostic tests (if any) have been done for this? \_\_\_\_\_

\_\_\_\_\_

What treatment(s) have you already received for this condition? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Has any treatment helped? (If yes, please explain) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you have any other health concerns? (Please list in order of importance):

1) \_\_\_\_\_

2) \_\_\_\_\_

3) \_\_\_\_\_

4) \_\_\_\_\_

5) \_\_\_\_\_

\* Are you pregnant or have any reason to believe you may be pregnant? Yes No

**Allergies:**

\*Are you allergic or hypersensitive to any foods, drugs, or environmental allergens?

Yes No If yes, please describe: \_\_\_\_\_

Are you currently suffering from any chronic illness?

Yes No If yes, please describe: \_\_\_\_\_

Have you ever been treated with acupuncture before? Yes No

If yes when: \_\_\_\_\_ by whom? \_\_\_\_\_

**Major Medical:**

Please list hospitalizations, surgeries, illnesses, traumas you have experience in your life:

- 1) \_\_\_\_\_ Date: \_\_\_\_\_
- 2) \_\_\_\_\_ Date: \_\_\_\_\_
- 3) \_\_\_\_\_ Date: \_\_\_\_\_
- 4) \_\_\_\_\_ Date: \_\_\_\_\_
- 5) \_\_\_\_\_ Date: \_\_\_\_\_

**Current Medications:**

Please list all prescription medications, over-the-counter medications, vitamins, herbs, or supplements you are currently taking and reason for taking them:

- 1) \_\_\_\_\_ dosage: \_\_\_\_\_ reason: \_\_\_\_\_
- 2) \_\_\_\_\_ dosage: \_\_\_\_\_ reason: \_\_\_\_\_
- 3) \_\_\_\_\_ dosage: \_\_\_\_\_ reason: \_\_\_\_\_
- 4) \_\_\_\_\_ dosage: \_\_\_\_\_ reason: \_\_\_\_\_
- 5) \_\_\_\_\_ dosage: \_\_\_\_\_ reason: \_\_\_\_\_

**Nutrition:**

Are you a vegetarian or vegan? Yes No

Are you on any specific diets? Yes No

**Other:**

Do you smoke cigarettes? Yes No If yes, how many per day? \_\_\_\_\_

Do you drink alcohol? Yes No If yes, how many drinks per week? \_\_\_\_\_

Is there anything else you would like me to know about you? \_\_\_\_\_

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Overall, the state of your health is:

Excellent

Good

Average

Fair

Poor

How much change are you willing to make for improving your health?

Minimal

Some

Complete

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- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Frequent urination  | <input type="checkbox"/> Frequent colds      | <input type="checkbox"/> Muscle spasms              |
| <input type="checkbox"/> Painful urination   | <input type="checkbox"/> Easily chilled      | <input type="checkbox"/> Sciatica                   |
| <input type="checkbox"/> Incontinence        | <input type="checkbox"/> Easily fatigued     | <input type="checkbox"/> Painful joints             |
| <input type="checkbox"/> Urinary retention   | <input type="checkbox"/> Weak limbs          | <input type="checkbox"/> Arthritis                  |
| <input type="checkbox"/> Wake up to urinate  | <input type="checkbox"/> Nightmares          | <input type="checkbox"/> Muscular pains             |
| <input type="checkbox"/> Dark colored urine  | <input type="checkbox"/> Mentally restless   | <input type="checkbox"/> Tight or painful neck      |
| <input type="checkbox"/> Urethral discharge  | <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Tight or painful shoulder  |
| <input type="checkbox"/> Night sweats        | <input type="checkbox"/> Colitis             | <input type="checkbox"/> Headaches                  |
| <input type="checkbox"/> Low back pain       | <input type="checkbox"/> Diverticulitis      | <input type="checkbox"/> Migraines                  |
| <input type="checkbox"/> Impaired hearing    | <input type="checkbox"/> Palpitations        | <input type="checkbox"/> Heat intolerance           |
| <input type="checkbox"/> Ear                 | <input type="checkbox"/> Chest pains         | <input type="checkbox"/> Cold intolerance           |
| <input type="checkbox"/> Low sex drive       | <input type="checkbox"/> Leg cramps          | <input type="checkbox"/> Brittle nails              |
| <input type="checkbox"/> Impotence           | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Bitter taste               |
| <input type="checkbox"/> Loose teeth         | <input type="checkbox"/> Anemia              | <input type="checkbox"/> Lump in the throat         |
| <input type="checkbox"/> Knee problems       | <input type="checkbox"/> Ankle swelling      | <input type="checkbox"/> Pains under ribs           |
| <input type="checkbox"/> Afternoon fatigue   | <input type="checkbox"/> Allergies           | <input type="checkbox"/> Enlarged lymph nodes       |
| <input type="checkbox"/> Kidney stones       | <input type="checkbox"/> Insomnia            | <input type="checkbox"/> Numbness                   |
| <input type="checkbox"/> Other stones        | <input type="checkbox"/> Nervousness         | <input type="checkbox"/> Dizziness                  |
| <input type="checkbox"/> Diarrhea            | <input type="checkbox"/> Forgetfulness       | <input type="checkbox"/> Eye problems               |
| <input type="checkbox"/> Loose stool         | <input type="checkbox"/> Excessive Sweating  | <input type="checkbox"/> Easily angered             |
| <input type="checkbox"/> Loss of Appetite    | <input type="checkbox"/> Low blood pressure  | <input type="checkbox"/> Depression                 |
| <input type="checkbox"/> Difficult to awaken | <input type="checkbox"/> Dry cough           | <input type="checkbox"/> Irritability               |
| <input type="checkbox"/> Edema               | <input type="checkbox"/> Dry skin            | <input type="checkbox"/> Easily bruised             |
| <input type="checkbox"/> Sore throat         | <input type="checkbox"/> Itching             | <input type="checkbox"/> Difficult to stop bleeding |