

Eric M. Baron, M.S., L.Ac., Dipl.Ac.
36 W 44th Street, Ste 401
New York, NY 10036
212-575-1360
212-398-8356 Fax Number

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? _____

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

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