

Dr. Steven L. Benedict, L.Ac., O.M.D., Dipl. O.M., C.F.M.C.

EastWestHealth.org

Acupuncture and Oriental Medicine

Integrative Functional Medicine, Nutrition

11901 Santa Monica Boulevard, Suite 110-545

Los Angeles, CA 90025

Phone: 310-442-7697

Note: The Pine Tree Center Office is located at 20002 Pine Tree Mine Road, Tehachapi, CA 93561

Dear _____,

Thank you for scheduling your health consultation appointment. I look forward to supporting you to achieve your optimal health! Please complete the attached Health Questionnaire and return it to me by mail or email in advance of your appointment.

Please also send me any recent lab test results or other information which you would like to discuss during your initial consultation.

Your appointment is scheduled for: _____.

If your appointment is for a telehealth call, I will call you at the numbers listed on your Questionnaire. If you have a preferred number, please circle that on your Questionnaire.

If we are meeting in person at the Pine Tree Center, I will meet you there at the appointed time.

Sincerely yours,

Dr. Steven L. Benedict, L.Ac., O.M.D., Dipl.O.M., C.F.M.C.

Licensed Acupuncturist

Doctor of Oriental Medicine

Diplomate Oriental Medicine (National Board Certification – NCCAOM)

Certified Functional Medicine Clinician (Kharrazian Institute)

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Please complete the following health questionnaire before having your initial appointment.

Name _____ Date _____ Soc. Sec. # (Optional) _____
 Address _____ City _____ State ____ Zip _____
 Male/ female _____ Date of birth _____ Age _____
 Married _____ Separated _____ Divorced _____ Widowed _____ Single _____ Height: _____ Weight: _____
 Number of children _____ Children's age's _____ Referred by _____
 Phone: (home) _____ (business) _____ (other) _____
 Email: _____

MEDICAL HISTORY

1. Check () any of the following that apply:

- Alcoholism*
- Arthritis*
- Cancer*
- Dementia*
- Depression*
- Diabetes*
- Epilepsy*
- Glaucoma*
- Heart trouble*
- Hepatitis*
- Hypertension*
- Kidney trouble*
- Osteoporosis*
- Stomach Ulcer*
- Stroke*
- Thyroid + / -*
- Tuberculosis*
- Other* _____
- Other* _____

YOU																				
Father																				
Mother																				
Brothers																				
Sisters																				
Spouse																				
Children																				
Maternal Grandparents																				
Paternal Grandparents																				

2. Check () any of the following that you have had:

- ___ anemia ___ eye disease ___ gall stones ___ gout ___ polio ___ eczema ___ hemorrhoids ___ liver disease
- ___ chicken pox ___ rheumatic fever ___ bronchitis ___ shingles ___ malaria ___ measles ___ migraine headache
- ___ diverticulitis ___ hernia ___ neuralgia ___ mononucleosis ___ emphysema ___ pancreatitis ___ mumps ___ jaundice

3. Check any of the following that you have had and approximately when:

<input checked="" type="checkbox"/> (Year) _____	Tests and Procedures	<input checked="" type="checkbox"/> (Year) _____	Immunizations
___ _____	blood testing	___ _____	chickenpox
___ _____	bone density scan	___ _____	flu
___ _____	colonoscopy	___ _____	hepatitis
___ _____	complete physical exam	___ _____	polio
___ _____	electrocardiogram (EKG)	___ _____	shingles
___ _____	mammogram (women)	___ _____	tetanus
___ _____	pap smear (women)	___ _____	measles
___ _____	prostate exam (men)	___ _____	mumps
___ _____	X-Ray or MRI	___ _____	other

4. Have you ever been hospitalized? Yes ___ No ___ If so, when and why? _____
5. List any known allergies you have to foods, drugs, and other substances: _____
6. Are you currently being treated by someone else? Yes ___ No ___ If so, why? _____
7. Have you previously been treated with Acupuncture and Oriental Medicine? Yes ___ No ___ If so, why? _____
8. List any medications which you currently take: _____

9. List any nutritional supplements and herbs which you currently take: _____

10. <u>Past Major illnesses, injuries, accidents, head traumas, surgeries:</u>	<u>Date or Age</u>
_____	_____
_____	_____
_____	_____

11. Have you taken or do you currently take any of the following?
 Birth control pills _____ Cortisone/Prednisone _____ Antibiotics _____
 Estrogen _____ Thyroid medication _____ Allergy shots _____
 Progesterone _____ Testosterone _____ Accutane _____
12. Do you wear contacts? _____ Dentures? _____ Pacemaker? _____
13. Have you ever had a tissue mineral or hair mineral analysis? _____ If so, when? _____
14. Have you ever used nicotine? _____ In what form and for how long? _____
15. Do you currently use nicotine? _____ In what form and how often? _____ Do you want to quit? _____
16. Do you drink caffeine beverages? _____ In what form and how often? _____
17. Do you drink alcohol? _____ In what form and how often? _____
18. Do you use cannabis? _____ In what form and how often? _____
19. How much water do you drink per day? _____
20. Please describe what your own birth was like, if known: _____

LIFESTYLE

- How many hours per week do you spend outside? _____ Do you usually wear sunglasses when you are outside? _____
- How many hours per week do you watch T.V.? _____ How many hours per week do you work at a computer? _____
- How often do you exercise? _____ What forms of exercise do you enjoy? _____
- What hobbies do you enjoy? _____
- How often do you take vacations? For how long? _____

DIET SURVEY

1. What do you usually eat for breakfast? _____
 _____ When do you eat breakfast? _____
2. For lunch? _____
 _____ When do you eat lunch? _____
3. For dinner? _____
 _____ When do you eat dinner? _____
4. Circle any of the following which you regularly crave: sweet, sour, bitter, salty, spicy, hot temps, cold temps.
5. How often do you prepare your own meals? _____

SYMPTOMS REVIEW

Directions: Circle any of the following symptoms that have bothered you in the past 6 months. Please make any additional comments in the space provided to the right.

<u>SYMPTOMS</u>	<u>COMMENTS</u>
<u>Head:</u>	
Headaches	Sore scalp/dandruff
Dizziness	Hair loss
<u>Eyes:</u>	
Dry eyes	Excessive tearing
Red eyes	Double vision
Blurred vision	Other vision problems
<u>Ears:</u>	
Poor hearing	Ear ringing
Earaches	Deafness
Ear discharge	Other ear problems
<u>Nose:</u>	
Poor sense of smell or taste	Frequent colds
Nasal obstruction	Sinus pain
Frequent nose bleeds	Post-nasal drip
<u>Mouth:</u>	
Bleeding gums	Ulcers
Sore tongue	Herpes sores
Dry lips	Dry mouth
Dental pain	Other dental problems
<u>Throat:</u>	
Sore throats	Difficulty swallowing
Tonsillitis	Spitting up mucus often
Hoarseness	
<u>Respiratory:</u>	
Cough	Bloody sputum
Thick sputum	Pain with breathing
Wheezing	Shortness of breath

SYMPTOMS

COMMENTS

Heart:

Chest pain or pressure	Heart palpitations
Irregular heart beat	Feet or ankle swelling
Varicose veins	Leg cramps
Shortness of breath	Difficulty lying flat
Exercise intolerance	Cold extremities
Bruise or bleed easily	

Skin:

Rash	Pigment changes
Dryness	Changing moles or lumps
Itching	Acne

Stomach:

Poor appetite	Pain with eating
Excessive appetite	Intestinal gas
Poor digestion	Nausea
Heartburn	Belching
Vomiting	Sleepy after eating
Food allergies	Ulcers

Intestines:

Diarrhea	Dry or hard stool
Constipation	Loose or watery stool
Hemorrhoids	Undigested food in stool
Hernia	Blood in stool
Mucus in stool	Stool painful to pass
Abnormal stool color	Use laxatives often
How often do you have bowel movements?	_____

Urinary:

Frequent urination	Loss of force of urine stream
Frequent bladder infections	Need to urinate at night
Pain or burning with urination	Dribbling after urination
Change in quantity of urine	Urination with cough or sneeze
Hesitancy with urination	**How often do you urinate each day? _____

SYMPTOMS

COMMENTS

Reproduction:

Decreased sexual desire Excessive sexual desire

History of sexually transmitted disease:

___ genital herpes ___ chlamydia ___ gardnerella ___ syphilis ___ gonorrhea

___ genital warts (HPV) ___ trichomonas ___ HIV or AIDS ___ Other

Frequency of intercourse: _____

Method of contraception: _____

Are you or your partner trying to become pregnant? _____

Sexual orientation: _____

Men:

Premature ejaculation Discharge from penis

Nocturnal emission Low sperm count

Prostate problems Difficulty getting or keeping erection

Difficulty impregnating Pain or coldness in genitals

Testicular lumps/swelling Male sexual partners

Date of last prostate exam? _____ Date of last PSA blood test? _____

Women:

Breast tenderness Breast lumps

Nipple discharge Difficulty getting pregnant

Vaginal pain Vaginal discharge

Vaginal dryness Vaginal bumps or sores

Vaginal itching Uterine fibroids

Endometriosis Painful intercourse

Ovarian cysts

Date of last PAP test and pelvic exam? _____ Date of last mammogram? _____

Do you practice regular breast self exams? _____

Women - Menses:

No menstrual period Pre-menstrual emotional swings

Irregular periods Pre-menstrual bloating/swelling/pain

Menstrual cramps/pain Heavy blood flow

Spotting between periods Light blood flow

Age at first period? _____ Are you or might you be pregnant? _____

Date of your last period? _____ Number of pregnancies? _____

How many days apart are your periods? _____ How long is your menstrual flow? _____

Number of miscarriages? _____ Number of abortions? _____

SYMPTOMS

COMMENTS

Endocrine:

Neck enlargement
Hair or nail changes
Intolerance to heat or cold
Hot flashes/abnormal sweating
Constant thirst

Neurological:

Nervousness	Numbness or tingling in hands/feet
Tremors or shaking	Convulsions
Incoordination	Paralysis
Drowsiness	Memory changes
Nerve pain (neuralgia)	Difficulty concentrating

Musculoskeletal:

Joint pain	Muscle weakness
Joint swelling	Muscle cramps
Deformity	Back stiffness/pain
TMJ pain	Neck stiffness/pain

Sleep:

Insomnia	Wake up often at night
Hard to fall asleep	Wake up tired
Nightmares	Other sleep problems

What time do you go to bed? _____
Number of hours of sleep per night? _____

Emotional Health:

Frequent stress	Often feel irritable
Mood swings	Often feel happy
Often feel angry	Often feel guilty
Often feel lonely	Often feel sad or depressed
Often overwork	Often feel anxious
Often feel overwhelmed	Difficulty making decisions
Often feel pressured	Sometimes have suicidal thoughts

What are your greatest sources of stress right now? _____.

SYMPTOMS

COMMENTS

Job Related:

Excessive stress at work Feel bored at work
Frustrated at work Want to change jobs
What is your type of work or profession? _____
Total number of hours you spend driving per week? _____
Total number of hours you spend working per week? _____

General:

Abnormal weight gain Unexplained fever or chills
Abnormal weight loss Loss of feeling of well being
Fatigue Overweight/ underweight

Dental history:

1. Do you currently need dental work? _____ If so, what? _____
2. Number of fillings? _____ Type? (silver, gold, composite, etc.) _____
3. Number of teeth pulled: _____ Number of root canals: _____ Do you wear dentures or partials? _____
4. Do you currently have tooth pain? _____ If so, where? _____
5. Do you have jaw joint pain? _____
6. Do you grind your teeth at night? _____
7. Do you wear a bite appliance at night? _____
8. Did you experience any birth trauma at your own birth? _____ If so, please explain _____

Scars:

Do you have any major scars on your body? _____ If so, where? _____

Please list what concerns you the most about your health and well-being at this time:

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.

Thank you for completing this health questionnaire.

CANCELLATION POLICY

I understand that occasionally circumstances can arise which might make you unable to attend a scheduled appointment. To prevent any late cancellation charge to you, I ask that you please give me 24 hours notice of any cancellation, at which time I will be happy to reschedule your appointment. If less than 24 hours notice is given, you will be charged the full amount of the missed appointment.

Thank you in advance for your cooperation.

Sincerely,

Dr. Steven L. Benedict

I have read and agree to the cancellation policy above.

(Name)

(Date)