Earth and Sky Healing Arts, LLC
3417 Evanston Avenue N., #408, Seattle, WA 98103
Rebekah Ingalls LAc/EAMP, LMP 206-789-0456 www.earthnsky.com info@earthnsky.com

HEALTH HISTORY QUESTIONNAIRE

PLEASE PROVIDE US WITH YOUR COMPLETE HEALTH HISTORY. ALL INFORMATION WILL BE HELD CONFIDENTIAL.

Name:		Date:
Street Address:		
City:	State:	Zip:
Cell #:	Email:	
Date of Birth:	Age:	Place of Birth:
Occupation:		Work #:
Family Physician:		Phone:
Emergency Contact:		Phone:
Name of the person who referred you to this office:		

Reason for Seeking Treatment?
Onset of this condition (date/event)?
What aggravates this condition?
What alleviates this condition?

Please rate the degree of severity of your problem right now (mark an X):

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None Manageable Worst Imaginable

Have you been given a diagnosis for this issue? If so, what?	
What treatment have you received for this issue?	
When were you last seen by a medical doctor (date or approximate year)?	
Name of physician:	Reason for visit:
Please list medications you are currently taking (drugs, herbs, supplements, vitamins, etc):	
Please list any allergies that you have (pollen, food, lotion, etc.)	

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Past Medical Problems (type and date):
Surgeries (type of and date):
Significant Trauma (auto accidents, falls, etc.):
Describe any pain you are experiencing **other than already specified** (location/duration/quality):

For All: (Please check all that are or have been applicable to you – if past, indicate age or date.)

General:

☐ Poor appetite	☐ Fevers	☐ Sweat easily
☐ Localized weakness	☐ Bleed or bruise easily	☐ Peculiar tastes or smells
☐ Strong thirst (for hot or cold)	☐ Thirst, but no desire to drink	☐ Sudden energy drop
☐ Poor sleeping	☐ Chills	☐ Tremors
☐ Poor balance	☐ Fatigue	☐ Night sweats
☐ Weight loss	☐ Change in appetite	☐ Weight gain

☐ Cravings, for what: _____

Skin and Hair:

☐ Rashes	☐ Itching	☐ Dandruff
☐ Change in hair or skin	☐ Ulcerations	☐ Eczema
☐ Loss of hair	☐ Hives	☐ Pimples
☐ Recent moles	☐ Other, please specify: _____	

Head, eyes, ears, nose and throat:

☐ Dizziness	☐ Glasses	☐ Poor vision
☐ Cataracts	☐ Ringing in the ears	☐ Sinus problems
☐ Teeth grinding	☐ Teeth problems	☐ Eyes strain
☐ Night blindness	☐ Blurry vision	☐ Poor hearing
☐ Nose bleeds	☐ Facial pain	☐ Jaw clicks, aches
☐ Migraine	☐ Eye pain	☐ Color blindness
☐ Earaches	☐ Spots in front of the eyes	☐ Recurrent sore throats
☐ Sores on lips or inside mouth	☐ Headaches, where on head: _____	

☐ Other, please specify: _____

Cardiovascular:

☐ High blood pressure	☐ Irregular heartbeat	☐ Cold hands and feet
☐ Blood clots	☐ Low blood pressure	☐ Dizziness
☐ Swelling of hands	☐ Phlebitis	☐ Chest pain
☐ Fainting	☐ Swelling of feet	☐ Difficulty breathing

☐ Other heart or blood vessel problems: _____

Respiratory:

☐ Cough	☐ Bronchitis	☐ Difficulty breathing lying down
☐ Coughing or blowing nose	w/ phlegm: what color? _____	☐ Coughing blood
☐ Pneumonia	☐ Asthma	☐ Pain on breathing

☐ Other lung or breathing problems: _____

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Gastrointestinal:

- ☐ Nausea
- ☐ Constipation
- ☐ Diarrhea
- ☐ Black stools
- ☐ Bad breath
- ☐ Abdominal pain or cramps
- ☐ Chronic laxative use
- ☐ Vomiting
- ☐ Gas
- ☐ Blood in stools
- ☐ Rectal pain
- ☐ Belching
- ☐ Indigestion
- ☐ Hemorrhoids
- ☐ Other stomach or intestinal problems: _____

Genito-Urinary:

- ☐ Pain on urination
- ☐ Urgency to urinate
- ☐ Decrease in flow
- ☐ Unable to hold urine
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Sores on genitals
- ☐ Other kidney or urogenital problems: _____

Musculoskeletal:

- ☐ Neck pain
- ☐ Back pain
- ☐ Hand/wrist pain
- ☐ Muscle pain
- ☐ Muscle weakness
- ☐ Shoulder pain
- ☐ Knee pain
- ☐ Foot/ankle pain
- ☐ Hip pain
- ☐ Other: _____

Neuropsychological:

- ☐ Seizures
- ☐ Areas of numbness
- ☐ Concussion
- ☐ Bad temper
- ☐ Dizziness
- ☐ Lack of concentration
- ☐ Depression
- ☐ Easily susceptible to stress
- ☐ Loss of balance
- ☐ Poor memory
- ☐ Anxiety
- ☐ Other: _____

For men only: (Please check all that are or have been applicable to you – if past, indicate age or date.)

- ☐ Decreased sex drive
- ☐ Impotency
- ☐ Low sperm count
- ☐ Exhaustion after sex
- ☐ Difficult urination
- ☐ Nighttime urination
- ☐ Scanty ejaculation
- ☐ Premature ejaculation
- ☐ Loss of force when urinating
- ☐ Dribbling after urination

For women only: (Please check all that are or have been applicable to you – if past, indicate age or date.)

- ☐ Irregular period
- ☐ No period
- ☐ Sweet cravings
- ☐ Nervousness
- ☐ Took birth control pills
- ☐ Heavy period
- ☐ Tender breasts before period
- ☐ PMS
- ☐ Fluid retention
- ☐ Mood swings
- ☐ Decreased sex drive
- ☐ Habitual miscarriage
- ☐ Infertility
- ☐ Vaginal discharge
- ☐ Scanty menses
- ☐ Heavy menses
- ☐ Breast pain
- ☐ Uterine fibroids
- ☐ Breast lumps
- ☐ Uterine hemorrhage

Age when menses started: _____ Age when menopause started: _____

Pregnancies: _____ Date/Age: _____

Miscarriages: _____ Date/Age: _____

Abortions: _____ Date/Age: _____

Comments: (please tell me about any other issue(s) you would like to discuss):

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Consent Form for Oriental Medicine Treatment

I, _____, hereby authorize Rebekah Ingalls to perform the following specific procedures:

Acupuncture: insertion of thin, sterilized needles into the skin and underlying tissues at specific points on the body.

Cupping: a technique to relieve symptoms in which cups are placed on the skin with a vacuum created by heat or other devices.

Plum Blossom: a light tapping of an area of the body with a small sterile hammer that has seven points.

Gua Sha: a rubbing on an area of the body with a blunt, round instrument.

Herbs: may be given in the form of pills, powders, tinctures, pastes, plasters, or raw herbs. Herbs may be taken internally or used externally, and may include shell, mineral, and animal materials. *Note: Over 98% of the herbs used are botanical. Conditions may call for the use of an animal product. Do you wish to be informed if this is the case?* ***[ ] Yes [ ] No***

Dietary Advice: based on East Asian Medical principles

Moxa: indirect or direct burning of mugwort leaf (*artemesia*) on specific areas of the body.

Tui Na/Acupressure: a form of Chinese bodywork that may include massage, sustained pressure points or stretching.

Electro-acupuncture: stimulation of acupuncture points with a mild electrical current.

Heating Lamp and Heating Pad: warms areas of the body.

I recognize the potential risks and benefits of these procedures as described below:

Potential side effects: May include but are not limited to discomfort, pain, minor bruising, infection and blistering at the site of the procedure, broken or unremoved needles, temporary discoloration of the skin, loose bowel movements, abdominal cramping, and aggravation of symptoms existing prior to treatment. Occasionally needle sickness may occur (dizziness, nausea, or fainting). Risk of needle shock increases for patients with low blood sugar or severe lack of sleep. For this reason, it is recommended that patients always eat prior to receiving treatment.

Potential benefits: Relief of symptoms, resolution of underlying condition, prevention of recurrence, and increased overall health.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Rebekah Ingalls**,** EAMP/L.Ac., LMP regarding cure or improvement of my condition. I agree to keep my practitioner updated and informed about any health changes that may occur. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. ***If you are pregnant, have a bleeding disorder, pacemaker or any active infections you must make that information known to your acupuncturist prior to treatment.**

I understand that a record will be kept of my health services provided to me. This record will be kept confidential and not be released to others without my consent, unless required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee.

I agree to pay the following fees: **$120.00** initial acupuncture visit, **$95** follow-up acupuncture visit, **$50** Herbal consultation, **$140** craniosacral /acupuncture visit 1.5 hours

I agree to give **24-hour cancellation notice** for any appointment or pay the full treatment fee. **Please Initial _____**

_____ _____
Signature of Patient, Representative, or Guardian Date