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):

0 ——————————————————————————————— 10

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

Genito-Urinary:

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

Musculoskeletal:

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

Neuropsychological:

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

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

- ☐ Decreased sex drive
- ☐ Low sperm count
- ☐ Difficult urination
- ☐ Scanty ejaculation
- ☐ Loss of force when urinating
- ☐ Impotency
- ☐ Exhaustion after sex
- ☐ Nighttime urination
- ☐ Premature ejaculation
- ☐ 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
- ☐ Sweet cravings
- ☐ Took birth control pills
- ☐ Tender breasts before period
- ☐ Fluid retention
- ☐ Decreased sex drive
- ☐ Infertility
- ☐ Scanty menses
- ☐ Breast pain
- ☐ Breast lumps
- ☐ No period
- ☐ Nervousness
- ☐ Heavy period
- ☐ PMS
- ☐ Mood swings
- ☐ Habitual miscarriage
- ☐ Vaginal discharge
- ☐ Heavy menses
- ☐ Uterine fibroids
- ☐ 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

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ACKNOWLEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The undersigned summarizes how health data about you may be used and shared ad how you can get access to this data. IMPORTANT NOTE: This does not include all of the details about our privacy policy. For more details, please read the NOTICE OF PRIVACY PRACTICES that your practitioner has provided you.

I. How we may use and share health data about you:
a) Treatment -to give you medical treatment of other types of health service
b) Payment – to bill you or a third party for payment for services provided to you
c) Health Care Operations – for our own operations such as quality control, compliance monitoring, audit, etc.
II. Disclosures where we do not have to give you a chance to agree or object:
a) To you
b) As required by federal, state, or local law
c) If child abuse or neglect is suspected
d) Public health risks (for public health activities to prevent and control spread of disease
e) Lawsuits and disputes (in response to a court or administrative order)
f) Law enforcement (to help law enforcement officials respond to criminal activities)
g) Coroners, medical examiners and funeral directors
h) Organ or tissue donation facilities if you are an organ donor
i) To avert a threat to an individual or to public health safety
I. Disclosures where we have to give you a chance to agree or object:
a) Patient directories: you can decide what health data, if any, you want to be listed in patient directories
b) Persons involved in your care or payment for your care – we may share your health data with a family member, a close friend, or other person that you have named as being involved with your health care.
IV. Other Uses of health data: Other uses not covered by this notice or the laws that apply to us will be made only with your written consent.
V. You have the following rights relating to the health data we keep about you:
a) Right to inspect your health record and to receive a copy of your health record upon request
b) Right to amend information in your health record you believe is inaccurate or incomplete
c) Right to know to whom we have disclosed your health information
d) Right to ask for limits on the health information data we give out about you
e) Right to receive communication from us about your health information in alternate ways
f) Right to a paper copy of the complete Notice of Privacy Practice

I acknowledge that I have received the NOTICE OF PRIVACY PRACTICES of this practice.

_____ _____
Patient Signature or representative signature Date

_____ _____
Print patient name Patient birth date

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Patient Notification of Qualifications and Scope of Practice

East Asian medicine means a health care service using East Asian medicine diagnosis and treatment to promote health and treat organic or functional disorders.

1. My qualifications include the following education and license information:
    a) Washington State East Asian Medicine Practitioner license #: AC 00002027
    b) Master's of Acupuncture and Oriental Medicine: Seattle Institute of Oriental Medicine, August 17, 2002.
    c)
2. The scope of practice for an East Asian medicine practitioner in the State of Washington includes the following:
    a) Acupuncture, including the use of acupuncture needles or lancets to directly or indirectly stimulate acupuncture points and meridians;
    b) Use of electrical, mechanica, or magnetic devises to stimulate acupuncture points and meridians
    c) Moxibustion
    d) Acupressure
    e) Cupping
    f) Dermal friction technique
    g) Infra-red
    h) Sonopuncture
    i) Laserpuncture
    j) Point injection therapy (acupuncture); and
    k) Dietary advice and health education based on East Asian medical theory, including the recommendation and sale of herbs, vitamins, minerals and dietary and nutritional supplements
    l) Breathing, relaxation and East Asian exercise techniques
    m) Qi gong
    n) East Asian massage and Tui Na, a method of East Asian bodywork, characterized by kneading, pressing, rolling, shaking, and stretching of the body and does not include spinal manipulation and
    o) Superficial heat and cold therapies
    p)
3. Side effects may include, but are not limited to
    a) pain following treatment
    b) Minor bruising
    c) Infection
    d) Needle sickness and
    e) Broken needle
    f)
4. The patient must inform the East Asian medicine practitioner if the patient has a severe bleeding disorder or pace maker prior to any treatment.

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Notice of Privacy Practices

The privacy of your health information has always been important to this clinic and we are committed to protecting it. Federal laws require that we provide each of our patients with an official notice of our privacy practices. This notice will inform you of ways we use and share your information and it will describe your rights and our duties regarding the use and disclosure of health information.

The law requires us to keep your health information private; give you this Notice of Privacy Practices, abide by its terms. We have the right to change our privacy practices and the terms of this notice at any time, provided permitted by the law. If we make changes, we will update this notice and make the new notice available upon request.

Listed here are some of the ways we may use or disclose your information without your specific consent or authorization. Not all possible uses or disclosures are listed. For treatment: we may use health information about you to provide you with treatment services. We may disclose health information about your to doctors, nurses, technicians, medical students or other people who are taking care of you. We may also share health information about you with other health care providers to assist them in treating you. For payment: we may disclose your health information for payment purposes. Other possible uses include: in response to a legal proceeding, for other healthcare provider's treatment activities, for other covered entities and provider's payment activities, in case of threat to public health or safety, to notify a family member in certain emergency situations, to workers' compensation or similar programs for processing of claims, in domestic violence or neglect situations. Other uses and disclosures not in this notice will be made only as allowed or required by law or with your written authorization.

The health and billings records we create are the property of this health care facility. The health information in it generally belongs to you.

You have a right to: request and receive from us a copy of the most current Notice of Privacy Practices, look at or receive copies of your health information (you may make this request in writing – we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request), ask us to restrict certain uses or disclosures by submitting the request in writing, have us review a denial of access to your health information – except in certain circumstances, ask us to change your health care information (you may give us the request in writing, write a statement of disagreement if the request is denied which will be stored in your medical record and will be included in any release of your records), request a list of disclosures of your health information, ask that your health information be given to you by other means or at another location (Please sign, date and give us your request in writing. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.), cancel a prior authorization to sue or disclose health information by giving us a written revocation. Your revocation does not affect any information that has already been released. It also does not affect any action taken before we have it. Sometimes you cannot cancel an authorization if its purpose was to obtain insurance.

If you have questions or wish to report a problem you may contact the Privacy Officer at 206-789-0456.

If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also file a complaint with the Privacy Officer at our practice or with the US Secretary of Health and Human Services. All complaints must be in writing. You will not be penalized or discriminated against for filing a complaint.