



Daniel L. Rasmussen MSAOM, EAMP  
509 Olive Way Ste 1407  
Seattle Wa, 98101  
206-619-2426  
[www.pin-acupuncture.com](http://www.pin-acupuncture.com)

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The following information is important to the maintenance of your account and/or your care. Please complete all the questions asked to the best of your ability. Do not hesitate to ask for assistance if needed. We will be happy to help you.

**PATIENT INFORMATION:**

Name \_\_\_\_\_ Social Security \_\_\_\_\_ Age \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Single \_\_\_\_\_  
Separated \_\_\_\_\_ Widowed \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_ Email \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_

**RESPONSIBLE PARTY (if under 18):**

Name of responsible party \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Zip \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell  
Phone \_\_\_\_\_ Email \_\_\_\_\_

**INSURANCE INFORMATION (Primary Insured):**

Subscriber's Name. \_\_\_\_\_ ID# \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Customer Service phone number \_\_\_\_\_ Subscriber's date of birth \_\_\_\_\_  
Relationship to subscriber \_\_\_\_\_ Secondary Insurance ID# \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Customer Service phone number \_\_\_\_\_ Subscriber's date of birth \_\_\_\_\_  
Relationship to subscriber \_\_\_\_\_

**EMERGENCY CONTACT/ NEXT OF KIN:**

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_  
Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_

## HEALTH HISTORY QUESTIONNAIRE

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Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment.

*All information is strictly confidential.*

Name of your primary physician: \_\_\_\_\_ Is there anything limiting you from care? No \_\_\_\_\_ Yes \_\_\_\_\_ - If so, what? \_\_\_\_\_  
Other physicians/therapists seen for the condition: \_\_\_\_\_

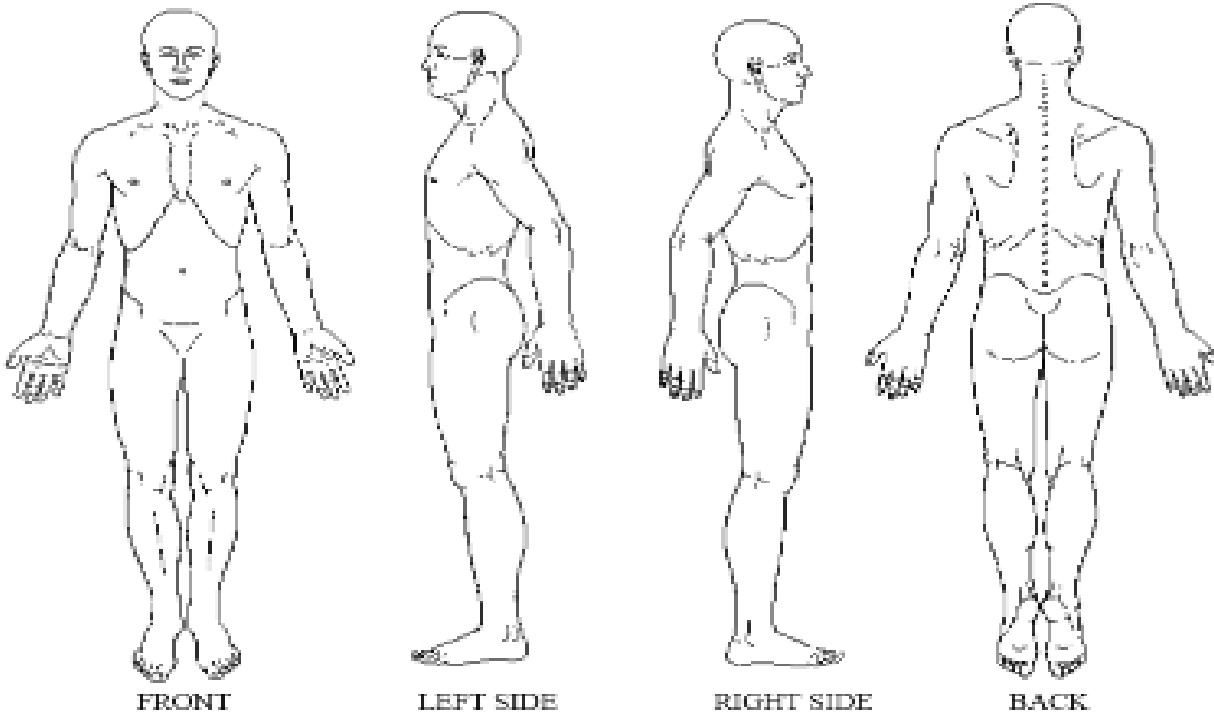
How did you hear about the office: \_\_\_\_\_

Medications you are currently taking:

1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_ 4) \_\_\_\_\_  
5) \_\_\_\_\_ 6) \_\_\_\_\_ 7) \_\_\_\_\_ 8) \_\_\_\_\_  
Prescribed by: \_\_\_\_\_ For treatment of: \_\_\_\_\_  
Results: \_\_\_\_\_

Supplements (if any, vitamins, herbs, minerals, etc.): \_\_\_\_\_

Please indicate areas of your body where you are experiencing pain/discomfort using the codes listed below.



**D**=Dull, **X**=Sharp, **N**=Numbness, **P**=Pins & Needles, **S**=Shooting/traveling, **B**=Burning

What caused your pain? (check all that apply) \_\_\_\_\_ Auto Accident \_\_\_\_\_ Work injury \_\_\_\_\_ Surgery (specify) \_\_\_\_\_  
\_\_\_\_\_. \_\_\_\_\_ Sports injury \_\_\_\_\_ Illness \_\_\_\_\_ No obvious cause

**Major complaints in order of significance to you:**

- 1. \_\_\_\_\_ Since \_\_\_\_\_
- 2. \_\_\_\_\_ Since \_\_\_\_\_
- 3. \_\_\_\_\_ Since \_\_\_\_\_
- 4. \_\_\_\_\_ Since \_\_\_\_\_
- Additional: \_\_\_\_\_ Since \_\_\_\_\_

**PATIENT MEDICAL HISTORY:**

How was your childhood health?

\_\_\_\_\_

Hospital Visits / Stays: \_\_\_\_\_

**Recent Medical Tests:**

- Cholesterol,            date \_\_\_\_\_ results \_\_\_\_\_
- Prostate,                date \_\_\_\_\_ results \_\_\_\_\_
- Blood,                    date \_\_\_\_\_ results \_\_\_\_\_
- HIV/STD,                date \_\_\_\_\_ results \_\_\_\_\_
- Pap Smear,              date \_\_\_\_\_ results \_\_\_\_\_
- Mammography,        date \_\_\_\_\_ results \_\_\_\_\_

***FEMALE ONLY***

\_\_\_\_\_

- \_\_\_\_\_ # of days of bleeding per cycle?
- \_\_\_\_\_ Are cycles regular?
- \_\_\_\_\_ PMS
- \_\_\_\_\_ # days between of cycles
- \_\_\_\_\_ Bleeding between cycles
- \_\_\_\_\_ Discharge
- \_\_\_\_\_ Painful menses
- \_\_\_\_\_ Endometriosis
- \_\_\_\_\_ Menopause symptoms
- \_\_\_\_\_ Breast lumps or pain
- \_\_\_\_\_ Nipple discharge
- \_\_\_\_\_ Do you do self breast-exams?
- \_\_\_\_\_ Age of first menses
- \_\_\_\_\_ Clotting
- \_\_\_\_\_ Heavy cycles
- \_\_\_\_\_ Abnormal paps
- \_\_\_\_\_ Ovarian cysts
- \_\_\_\_\_ # of pregnancies
- \_\_\_\_\_ # of miscarriages
- \_\_\_\_\_ # of live births
- \_\_\_\_\_ # of abortions

Do you practice birth control?  Y  N Type? \_\_\_\_\_ for how long? \_\_\_\_\_

Currently Pregnant?  Y  N

Do you experience any of the following PMS symptoms?

- Nausea                     Vomiting                     Water retention             Breast swelling
- Food cravings             Headaches                 Migraines                     Breast tenderness
- Depression                 Irritability                 Anxiety                       Other emotions: \_\_\_\_\_
- Dull pain? where? \_\_\_\_\_  Sharp pain? where? \_\_\_\_\_

\_\_\_\_\_

**A few final questions:**

1. On a scale of 1-10, how committed are you to improving your state of health? \_\_\_\_\_
2. On a scale of 1-10, how much change are you willing to make at this time for improving your state of health? \_\_\_\_\_

**AGREEMENT BY THE PATIENT REGARDING CANCELLED/MISSED APPOINTMENTS**

I understand that a missed appointment (No Show) will result in a \$40.00 charge being incurred for that appointment. I understand that patients arriving later than 15 minutes past the appointment time are not guaranteed their appointment time slot, and will be charged the full rate for that appointment. Failure to give the clinic at least 24 hours notice for the change of appointment will incur a \$25.00 fee for that appointment.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**AGREEMENT BY THE PATIENT / GUARANTOR TO BE FINANCIALLY RESPONSIBLE FOR FEES**

I (patient or guarantor) understand that I am financially responsible for all charges whether or not paid by my insurance. I am aware that some and perhaps all of the services provided may be non-covered services under my insurance. I am also aware that verification of insurance benefits is not a guarantee of payment. I also understand that a monthly interest rate of 1.5% will be applied to any unpaid patient balance over 30 days past due.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**MEDICAL RELEASE TO INSURANCE COMPANY**

I authorize the release of medical information to my insurance company / companies, including diagnosis and the record of treatment or examinations rendered to me during the period of such medical care, and also request by insurance company / companies to pay directly to Pinnacle Acupuncture LLC for those medical services.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Clinical Verification of Signatures \_\_\_\_\_ Date \_\_\_\_\_

*This form will be retained in your Medical Record.*