



Cassie Vasuma Lowe, L.Ac., MSAOM

Please check which location you will be visiting:

Tacoma Area

7501 33rd St. W.
University Place, WA 98466
Phone: (206) 795-6920

Seattle Area

3521 Stone Way N.
Seattle, WA 98103
Phone (206) 795-6920

Issaquah (Eastside)

245 E. Sunset Way
Issaquah, WA 98027
Phone: (206) 795-6920
Fax: (425) 427-8563

ACUPUNCTURE AND CHINESE HERBAL MEDICINE INFORMED CONSENT FOR TREATMENT

I, _____, hereby authorize the practitioner named above to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

Acupuncture: insertion of special sterilized needles through the skin into underlying tissues at specific points on the surface of the body.

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

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 other forms such as raw herbs to be cooked. Cooked herbs may be given to take internally or externally as a wash. Herbal formulas may include shell, mineral, and animal materials.

Moxa: indirect burning on an acupoint using stick, string, or ball moxa to relieve symptoms.

Tuina: an ancient massage used to treat a wide variety of common disharmonies

Dietary Advice: based on traditional Chinese Medical Theory

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

Potential risks: discomfort, pain, infection, or blistering at the site of the procedure; temporary discoloration of the skin; nausea, loose bowel movements, abdominal cramping; and aggravation of symptoms existing prior to the acupuncture treatment.

Potential benefits: drugless relief of presenting symptoms and improved balance of bodily energies, which may lead to prevention or elimination of the presenting problem and the strengthening of the body's constitution.

Notice to Pregnant Women: We do not use labor-stimulating acupuncture points unless the treatment is specifically for the induction of labor. A treatment intended to induce labor requires a letter from a primary care provider authorizing or recommending such a treatment. All female patients must alert the practitioner if they know or suspect they are pregnant.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by the practitioner or by any of her personnel regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Signature of Patient or Guardian

Date



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PATIENT INFORMATION

NAME:	DATE OF BIRTH:
HOME PHONE: OK to Call? Yes () No () Emergency Only Preferred contact number ()	WORK PHONE: OK to call? Yes () No () Emergency Only Preferred contact number ()
CELL PHONE: OK to Call? Yes () No () Emergency Only Preferred contact number ()	EMAIL ADDRESS: OK to email? Yes () No ()
PERSON TO CONTACT IN EMERGENCY:	RELATIONSHIP TO PATIENT:
HOME ADDRESS: NUMBER & ST CITY, STATE & ZIP	PLACE OF BUSINESS: POSITION HELD SOCIAL SECURITY #:

INSURANCE INFORMATION

INSURANCE COMPANY NAME:	GROUP NUMBER:
SUBSCRIBER:	SUBSCRIBER ID#
Is your condition related to work, injury, or auto accident? (Specify)	

FINANCIAL AGREEMENT & AUTHORIZATION FOR TREATMENT

I, the undersigned, have insurance coverage with (name of the insurance company or write "none" if uninsured) _____ and assign directly to Vasuma Cassie Lowe, L.Ac., all medical benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I hereby authorize your clinic to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Insured/Guardian/Patient _____ Date _____



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PATIENT HISTORY QUESTIONNAIRE

PERSONAL INFORMATION

Name:		Date:	
Sex:	Age:	Date of Birth:	Place of Birth:
Height:		Weight:	Occupation:
Relationships: <input type="checkbox"/> Married <input type="checkbox"/> Divorced/separated <input type="checkbox"/> Widowed <input type="checkbox"/> Single			
Regular Health Provider:		Specialty:	Phone:
Date of Last Medical Care:		Reason:	
Diagnosis of Problem: (If available)		May we contact your health care provider concerning your records? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Referred to this office by : Dr. [] Friend [] Yellow pages [] Ads [] Others []			
Yes <input type="checkbox"/> No <input type="checkbox"/> Have you had an acupuncture treatment before? Yes <input type="checkbox"/> No <input type="checkbox"/> Are you nervous about needles? Yes <input type="checkbox"/> No <input type="checkbox"/> Do you have a tendency to faint? Yes <input type="checkbox"/> No <input type="checkbox"/> Do you bleed for a long time or bruise easily? Yes <input type="checkbox"/> No <input type="checkbox"/> Are you extremely hungry at the present time? Yes <input type="checkbox"/> No <input type="checkbox"/> Are you extremely tired right now? Yes <input type="checkbox"/> No <input type="checkbox"/> Do you have hepatitis or AIDS? Yes <input type="checkbox"/> No <input type="checkbox"/> Have you ever had hepatitis? Yes <input type="checkbox"/> No <input type="checkbox"/> Do you have a pacemaker? Yes <input type="checkbox"/> No <input type="checkbox"/> Are you taking any medications now? Yes <input type="checkbox"/> No <input type="checkbox"/> Are you undergoing any other treatment therapies now? Yes <input type="checkbox"/> No <input type="checkbox"/> Women - are you pregnant?			

PRESENT HEALTH

What do you consider to be your most important health problem?
Reason for today's visit? (Specify)

FAMILY HISTORY

<p>Has any blood relative had any of the following?</p> <p>Cancer () Allergies () TB () Diabetes () Seizures () Stroke () Hypertension () Heart Disease () Thyroid Disease () Others:</p>	<p>General state of health/age of your parents & siblings: (If deceased, state cause)</p>
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MEDICAL HISTORY

<p>Past major illnesses:</p>	<p>Major accidents, falls, etc. :</p>
<p>Hospitalizations/surgeries/radiation treatments:</p>	<p>Location of all major scars:</p>
<p>Allergies to drugs, chemicals, foods, environment:</p>	

LIFESTYLE

<p>Work environment: What type of stress (chemical, physical and psychological) do you have in your job?</p>	<p>Exercise: Do you have a regular exercise program? If yes, describe it.</p>
<p>Sleep: Average hours of sleep each night</p> <p>Do you have difficulty sleeping? Often () sometimes () never ()</p> <p>Do you dream? Often () sometimes () never ()</p> <p>What type of dream:</p>	<p>Leisure: Describe your primary interests or hobbies.</p>

<p>Diet: Are you satisfied with your present diet? yes () no () explain: List any foods that you crave: List any foods that give you a bad reaction List all the foods and the time you eat on an average day:</p>			
Breakfast at	Lunch at	Dinner at	Snacks at
Food:.....	Food:.....	Food:.....	Food:.....
.....
.....
<p>Medicine and drugs: (List any medicines, vitamins, herbs and their dosage, taken in the past month.)</p>			
<p>Smoking: Don't smoke Quit, when Cigarettes per day Cigars per day</p>	<p>Drinking: Coffee/tea/cola per day Beer/wine per day Liquor per day</p>	<p>Other drugs used: Marijuana, cocaine, etc. Never/Rarely Sometimes Often</p>	

REVIEW OF SYSTEM

<p>If you are having any of the following problems at this time, please place a check on the line in front of it. Also, fill in the blanks where indicated.</p>			
General Condition			
<input type="checkbox"/> Fever	<input type="checkbox"/> Weight loss	<input type="checkbox"/> Swollen glands	<input type="checkbox"/> Night sweats
<input type="checkbox"/> Weight gain	<input type="checkbox"/> Strong thirst (cold or hot drink)	<input type="checkbox"/> Beer/wine per day	<input type="checkbox"/> Sweat easily
<input type="checkbox"/> Chills	<input type="checkbox"/> Hot soles & palms	<input type="checkbox"/> Feelings of cold	<input type="checkbox"/> Feelings of heat
<input type="checkbox"/> HIV (+) or AIDS	<input type="checkbox"/> Easily fatigued	<input type="checkbox"/> Energy drop at _____ (time of day)	
Skin and hair			
<input type="checkbox"/> Bruise easily	<input type="checkbox"/> Rashes	<input type="checkbox"/> Hives	<input type="checkbox"/> Pimples
<input type="checkbox"/> Itching	<input type="checkbox"/> Dry skin or hair	<input type="checkbox"/> Oil skin or hair	<input type="checkbox"/> Loss of hair
<input type="checkbox"/> Recent moles	<input type="checkbox"/> Abnormal growths	<input type="checkbox"/> Sores or wounds do not heal	
Head, Eyes, Ears, Nose, and Throat			
<input type="checkbox"/> Headaches	<input type="checkbox"/> Migraines	<input type="checkbox"/> Facial pain	<input type="checkbox"/> Dizziness or vertigo
<input type="checkbox"/> Glasses	<input type="checkbox"/> Poor vision	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Eye pain
<input type="checkbox"/> Spots in eyes	<input type="checkbox"/> Night blindness	<input type="checkbox"/> Color blindness	<input type="checkbox"/> Blurry vision
<input type="checkbox"/> Earaches	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Poor hearing	<input type="checkbox"/> Nose bleeds
<input type="checkbox"/> Nasal stuffiness	<input type="checkbox"/> Loss of smell	<input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Recurrent sore Throats
<input type="checkbox"/> Dry throat/mouth	<input type="checkbox"/> Lots of saliva	<input type="checkbox"/> Persistent hoarseness	<input type="checkbox"/> Sores on lips/tongue
<input type="checkbox"/> Jaw clicks	<input type="checkbox"/> Gum problems	<input type="checkbox"/> Grind teeth	
Neuropsychological system			
<input type="checkbox"/> Seizures	<input type="checkbox"/> Poor memory	<input type="checkbox"/> Frequent headaches	<input type="checkbox"/> Concussion
<input type="checkbox"/> Easily stressed	<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety/ fear	<input type="checkbox"/> Bad temper
<input type="checkbox"/> Crying spells	<input type="checkbox"/> Overwhelming joy	<input type="checkbox"/> Treated for mental problem	
<input type="checkbox"/> Don't know how to relieve stress			

Cardiovascular System

- High blood pressure Low blood pressure Chest pain & tightness Fast heartbeat
- Slow heartbeat Irregular heartbeat Fainting Swelling in limbs
- Leg pain when walk Leg vein trouble Bleeding disorder High cholesterol

Pulmonary System

- Cough Asthma Tight chest Coughing with blood
- Shortness of breath Bronchitis Difficulty breathing Color of sputum _____
- Frequent catching colds & flu

Gastrointestinal System

- Poor appetite Trouble swallowing Nausea Vomiting
- Belching Bad breath Bloating after meals Acid reflex
- Gas/cramping Loose stools Bloody stools Black stools
- Rectal pain Hemorrhoids Bowel movements frequency _____ times.

Hepatic and Biliary System

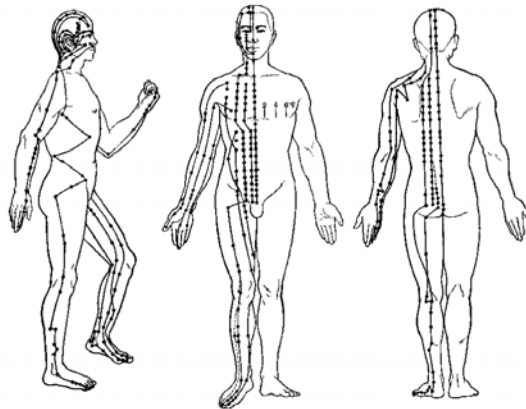
- Hepatitis Jaundice Hypochondriac pain Gall stone
- Cholecystitis Cirrhosis Ascites Liver enlargement

Genitourinary System

- Painful urination Burning urination Difficulty urinating Urgent need to urinate
- Blood in urine Kidney stones Urine scanty and dark Edema
- Frequent urination Incontinence STD Prostate trouble
- Discharge from penis Impotence Wake up to urinate at night _____ times.

Musculoskeletal System

- Joint pain/ stiffness Neck pain Muscle pain Upper back pain
- Localized weakness Lower back pain Numbness/ tingling Leg pain
- Pain interferes with normal daily activities Locations of problems (list below)



Pregnancy/Gynecological System

- Vaginal discharge Vaginal sores Breast lumps Nipple discharge
 - Are you pregnant now? Menopause PMS Fibroid
 - # of pregnancies _____ # of births _____ # stillborn/abortions _____ Birth control type _____
 - Last PAP smear _____ Last menses _____ Period: Every ____ days Lasts _____ days
- Please circle one in each category below:
- Cycle: Regular or Irregular Flow: Excessive, Scanty, Normal
- Blood: Dark Red, Bright Red, or Pale Red Clots present: Yes No
- Cramping: Yes No, If yes, pain is Before, During, or After the period.