



## Cassie Vasuma Lowe, L.Ac., MSAOM

Please check which location you will be visiting:

**Tacoma Area**

7501 33<sup>rd</sup> 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



**Cassie Vasuma Lowe, L.Ac., MSAOM**

**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 \_\_\_\_\_



**Cassie Vasuma Lowe, L.Ac., MSAOM**

**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 &amp; 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><b>Diet:</b>          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><b>Medicine and drugs:</b> (List any medicines, vitamins, herbs and their dosage, taken in the past month.)</p>			
<p><b>Smoking:</b>          Don't smoke .....          Quit, when .....          Cigarettes per day .....          Cigars per day .....</p>	<p><b>Drinking:</b>          Coffee/tea/cola per day .....          Beer/wine per day .....          Liquor per day .....</p>	<p><b>Other drugs used:</b>          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>			
<b>General Condition</b>			
( ) Fever	( ) Weight loss	( ) Swollen glands	( ) Night sweats
( ) Weight gain	( ) Strong thirst (cold or hot drink)	( ) Sweat easily	( ) Feelings of heat
( ) Chills	( ) Hot soles & palms	( ) Feelings of cold	( ) Energy drop at _____ (time of day)
( ) HIV (+) or AIDS	( ) Easily fatigued		
<b>Skin and hair</b>			
( ) Bruise easily	( ) Rashes	( ) Hives	( ) Pimples
( ) Itching	( ) Dry skin or hair	( ) Oil skin or hair	( ) Loss of hair
( ) Recent moles	( ) Abnormal growths	( ) Sores or wounds do not heal	
<b>Head, Eyes, Ears, Nose, and Throat</b>			
( ) Headaches	( ) Migraines	( ) Facial pain	( ) Dizziness or vertigo
( ) Glasses	( ) Poor vision	( ) Cataracts	( ) Eye pain
( ) Spots in eyes	( ) Night blindness	( ) Color blindness	( ) Blurry vision
( ) Earaches	( ) Ringing in ears	( ) Poor hearing	( ) Nose bleeds
( ) Nasal stuffiness	( ) Loss of smell	( ) Bleeding gums	( ) Recurrent sore Throats
( ) Dry throat/mouth	( ) Lots of saliva	( ) Persistent hoarseness	( ) Sores on lips/tongue
( ) Jaw clicks	( ) Gum problems	( ) Grind teeth	
<b>Neuropsychological system</b>			
( ) Seizures	( ) Poor memory	( ) Frequent headaches	( ) Concussion
( ) Easily stressed	( ) Depression	( ) Anxiety/ fear	( ) Bad temper
( ) Crying spells	( ) Overwhelming joy	( ) Treated for mental problem	
( ) 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**

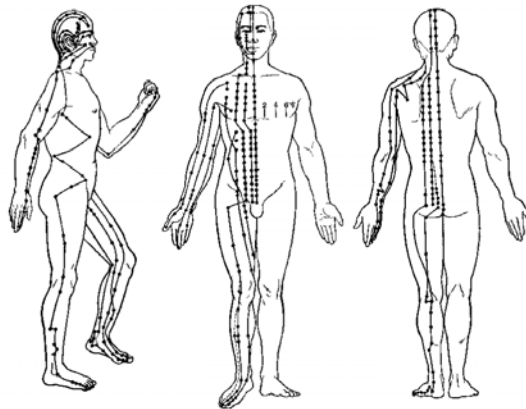
- Hepatitis     Jaundice     Hypochondriac pain     Gall stone
- Cholecystitis     Cirrhosis     Ascites     Liver enlargement

**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.