Cassie Vasuma Lowe, L.Ac., MSAOM

Please check which location you will be visiting:

☐ **Tacoma Area**
7501 33rd St. W.
University Place, WA
98466

☐ **Salish Cancer Center**
3700 Pacific Hwy E.
Suite 100
Fife, WA 98424
Phone: (253) 382-6300

☐ **Issaquah (Eastside)**
120 1st Ave.NW
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: 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 ( )
HOME ADDRESS: NUMBER & ST CITY, STATE & ZIP	PLACE OF BUSINESS: POSITION HELD SOCIAL SECURITY #:
PERSON TO CONTACT IN EMERGENCY:	RELATIONSHIP TO PATIENT and Phone:

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 compny 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 QUESTIONAIRE

PERSONAL INFORMATION

Name:			Date:
Sex:	Age:	Date of Birth:	Place of Birth:
Height:		Weight:	Occupation:
Relationships: [ ] Married [ ] Divorced/separated [ ] Widowed [ ] 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 [ ] No [ ]	
Referred to this office by : Dr. [ ] Friend [ ] Yellow pages [ ] Ads [ ] Others [ ]			

Yes [ ] No [ ] Have you had an acupuncture treatment before?
Yes [ ] No [ ] Are you nervous about needles?
Yes [ ] No [ ] Do you have a tendency to faint?
Yes [ ] No [ ] Do you bleed for a long time or bruise easily?
Yes [ ] No [ ] Are you extremely hungry at the present time?
Yes [ ] No [ ] Are you extremely tired right now?
Yes [ ] No [ ] Do you have hepatitis or AIDS?
Yes [ ] No [ ] Have you ever had hepatitis?
Yes [ ] No [ ] Do you have a pacemaker?
Yes [ ] No [ ] Are you taking any medications now?
Yes [ ] No [ ] Are you undergoing any other treatment therapies now?
Yes [ ] No [ ] 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

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

MEDICAL HISTORY

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

LIFESTYLE

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

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:

Breakfast at	Lunch at	Dinner at	Snacks at .....
Food:.....	Food:.....	Food:.....	Food:.....
.....	.....	.....	.....
.....	.....	.....	.....

Medicine and drugs: (List any medicines, vitamins, herbs and their dosage, taken in the past month.)

Smoking:	Drinking:	Other drugs used:
Don't smoke	Coffee/tea/cola per day	Marijuana, cocaine, etc.
Quit, when	Beer/wine per day	Never/Rarely .....
Cigarettes per day	Liquor per day	Sometimes .....
Cigars per day		Often .....

REVIEW OF SYSTEM

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.

General Condition

( ) Fever	( ) Weight loss	( ) Swollen glands	( ) Night sweats
( ) Weight gain	( ) Strong thirst (cold or hot drink)		( ) Sweat easily
( ) Chills	( ) Hot soles & palms	( ) Feelings of cold	( ) Feelings of heat
( ) HIV (+) or AIDS	( ) Easily fatigued	( ) Energy drop at _____ (time of day)	

Skin and hair

( ) 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	

Head, Eyes, Ears, Nose, and Throat

( ) 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	

Neuropsychological system

( ) 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 ( ) *I*rregular 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 ( ) Bloated after meals ( ) Acid reflex
( ) Gas/cramping ( ) Loose stools ( ) Bloody stools ( ) Black stools
( ) Rectal pain ( ) Hemorrhoids ( ) Bowel movements frequency _____ times.

Hepatic and Biliary System

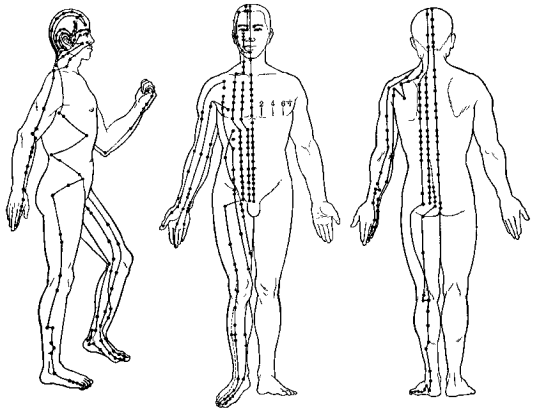
( ) Hepatitis ( ) Jaundice ( ) Hypochondriac pain ( ) Gall stone
( ) Cholecystitis ( ) Cirrhosis ( ) Ascites ( ) Liver enlargement

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.