ORIENTAL ACUPUNCTURE & THERAPY CLINIC, INC.

4026 N. Mesa (Centro El Rincon) Suite E. El Paso, Texas 79902
Clinic: (915) 351-9444 *www.orientalacupunctureelpaso.com*

QF OP NP

Date: _____
Time: _____

IMPORTANT REMINDERS:

By appointment only.
Fill out the form completely and come 15 minutes before your appointment.
For 8:30am and 1:30pm appointments, just come on time.
Eat a good solid meal 2 hours before your scheduled session.
Needles move internal energy within your body. Poor or lack of energy may cause your body to weaken, collapse or faint. If this happens, the session will be discontinued.
Wear a comfortable, non-restricting clothing.
For cancellation, refer to Appointment Cancellation Policy Agreement (p.3)

PERSONAL INFORMATION

Name: _____

Date of Birth: _____ Age: _____

Place of Birth: _____ Sex: _____

Address: _____

City:_____ State: _____ Zip: _____

Contact Number/s: _____

Height: _____ Weight: _____ Marital Status: _____

Employer Name: _____

Occupation: _____

Family Physician: _____

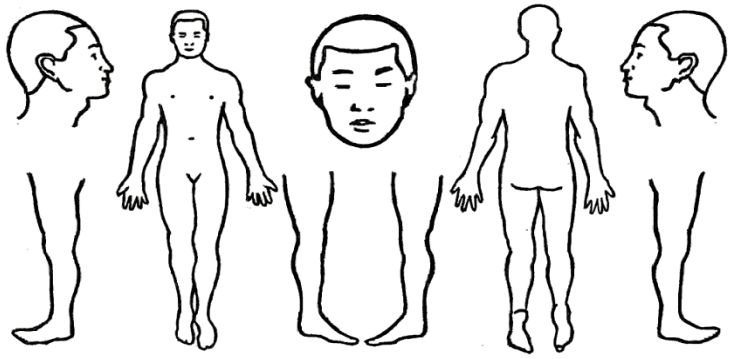
Referred by: _____

SUBJECTIVE INFORMATION

Main Problem/s: Date of Onset:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Shade the Affected/Distressed Areas:



Rate the Severity of the Problem:

0 1 2 3 4 5 6 7 8 9 10

No Problem *Worst*

Other of Mode of Treatments Tried:

_____
_____

PAST MEDICAL HISTORY

Your Birth History:

___ Normal Delivery
___ Prolonged Labor
___ Pre/Post Mature
___ Forceps Delivery
___ Caesarean Section
Others: _____

Allergies:
Food: _____
Medications / Drugs: _____
Others: _____

Other health issues you were diagnosed with: (Include date)

___ Allergies ___ Diabetes ___ Psychiatric
___ ADD/ADHD ___ Heart Problem ___ Rheumatic Fever
___ Asthma ___ Blood Pressure ___ Stroke
___ Arthritis ___ Kidney Problem ___ Venereal Disease
___ Cancer ___ Liver Problem Others: _____

Significant Traumas / Injuries: (Include date)

___ Contact ___ Fall ___ Sports ___ Vehicular
Others: _____

Previous Surgeries: (Include date)

_____
_____
_____

FAMILY MEDICAL HISTORY

___ Allergies ___ Diabetes ___ Psychiatric
___ ADD/ADHD ___ Heart Problem ___ Rheumatic Fever
___ Asthma ___ Blood Pressure ___ Stroke
___ Arthritis ___ Kidney Problem ___ Venereal Disease
___ Cancer ___ Liver Problem Others: _____

CURRENT HEALTH STATUS

What are you taking within the last 2 months?
Prescription/Maintenance Drugs: _____
_____
Vitamins: _____
Herbal Supplements: _____
Others: _____

Describe/Enumerate what consists of your regular meals:
(Example: Cereals, Bread, Chicken, Soup, etc.)
Breakfast: _____
Lunch: _____
Dinner: _____

Are you a cigarette smoker? _____ Since when? _____
If yes, how many sticks a day? _____

How much water do you take within 24 hours? _____ glasses

Estimated intake of other beverages per week:
Coffee: _____ Soda: _____
Energy Drinks: _____ Alcoholic Beverages: _____

Do you use any drugs for non-medical purposes? _____
If yes, please describe: _____

CHECK ANY YOU HAVE HAD WITHIN THE LAST 3 MONTHS

GENERAL

___ Chills
___ Fevers
___ Night sweats
___ Localized weakness
___ Bleed/ bruise easily
___ Peculiar tastes/smell
___ Strong thirst (hot/cold)
___ Thirst, no desire to drink
___ Fatigue
___ Sudden drop of energy.
Time of the day? _____
___ Edema.
Where? _____
___ Poor sleeping
___ Tremors
___ Poor balance
___ Cravings
___ Change in appetite
___ Weight gain
___ Weight loss
Others: _____

SKIN AND HAIR

___ Rashes
___ Itching
___ Change in hair / skin
___ Ulcerations
___ Eczema
___ Oozing in skin lesions
___ Hives
___ Pimples
___ Recent moles
___ Loss of hair
___ Dandruff
Others: _____

RESPIRATORY

___ Cough
___ Asthma/wheezing
___ Difficulty breathing
when lying down
___ Productive phlegm
Color: _____
___ Coughing blood
___ Pneumonia
___ Bronchitis
Others: _____

HEAD, EYES, EARS, NOSE, THROAT

___ Dizziness
___ Migraines
___ Headaches
When? _____
Where? _____
___ Facial pain
___ Eye glasses
___ Poor vision
___ Night blindness
___ Blurry vision
___ Color blindness
___ Blind field
___ Spots in front of eyes
___ Eye pain
___ Eye strain
___ Cataracts
___ Eye dryness
___ Excessive tears
___ Discharges from eyes
___ Poor hearing
___ Ringing in ears
___ Earaches
___ Discharges from ears
___ Nose bleeds
___ Sinus Congestion
___ Nasal drainage
___ Grinding teeth
___ Teeth problems
___ Clicking of jaw
___ Concussions
___ Recurrent sore throat
___ Hoarseness
___ Lips / tongue sores
Others: _____

CARDIOVASCULAR

___ High blood pressure
___ Low blood pressure
___ Chest pain/discomfort
___ Heart palpitations
___ Cold hands/feet
___ Swelling of feet
___ Blood clots
___ Fainting
___ Difficulty breathing
Others: _____

GASTROINTESTINAL

___ Bad breath
___ Nausea
___ Vomiting
___ Heartburn
___ Belching
___ Gas
___ Bloating
___ Indigestion
___ Diarrhea
___ Constipation
___ Chronic use of laxatives
___ Blood in stools
___ Abdominal pain/cramps
___ Rectal pain
___ Hemorrhoids
Others: _____

GENITO-URINARY

___ Pain during urination
___ Urgency to urinate
___ Frequent urination
___ Decrease in flow
___ Urinary dribbling
___ Kidney stones.
Size: _____
___ Impotency
___ Change of sexual drive
___ Genital sores
Do you wake up to urinate?
____ Yes ____ No
How often? _____
Any particular color of urine?
_____
Others: _____

MUSCULOSKELETAL

Body Pains:
___ Neck
___ Shoulder
___ Back
___ Elbow
___ Hand
___ Wrist
___ Hip
___ Knee
___ Foot
___ Ankle
___ Muscles
___ Joints
Others: _____

PREGNANCY AND GYNECOLOGY

___ Number of pregnancies
___ Number of births
___ Premature births
___ Miscarriages
___ Abortions
___ Age at first menses
___ Period between menses
___ Duration of menstruation
___ First date of last menses
___ Unusual color (heavy/light)
___ Painful menstruation
___ Irregular menstruation
___ Body/psyche changes
prior to menstruation
___ Blood clots
___ Menopause: Age: _____
___ Vaginal discharge
___ Post-coital bleeding
___ Vaginal sores
___ Breast lumps
___ Nipple discharges
Last Pap Smear? _____
Do you practice birth control?
___ Yes ___ No
What type and for how long?
_____
Others: _____

NEUROPSYCHOLOGICAL

___ Seizures
___ Areas of numbness
___ Weakness
___ Sleep disorder
___ Concussion
___ Bad temper
___ Loss of control
___ Potential for violence
___ Vertigo
___ Lack of coordination
___ Depression
___ Easily susceptible to stress
___ Loss of balance
___ Poor memory
___ Anxiety
___ Substance abuse
Others: _____

Have you been ever treated for emotional problems?
___ Yes ___ No
Have you ever considered or attempted suicide?
___ Yes ___ No

CONSENT FORM FOR TRADITIONAL MODE OF TREATMENT

I, the undersigned hereby authorize **EDWARD Z. SALOMA**, the Acupuncturist of **ORIENTAL ACUPUNCTURE AND THERAPY CLINIC, INC.**, to perform any of the following specific procedures:

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

Cupping A technique to relieve symptoms with cups made of glass, bamboo, or other materials put on the skin with a vacuum created by using heat or other devices.

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

Tuina An ancient massage technique used to treat a wide variety of common disharmonies.

Ear Pellets Tiny pellets attached to skin-colored/transparent adhesive surgical tape, and are applied to precisely located points on the outer ear.

I recognize the potential risks and benefits of this procedure as described below:

Potential Risks - Discomfort, pain, infection and blistering at the site of procedure, temporary discoloration of skin and even an aggravation of existing symptoms, muscle soreness and dizziness.

Potential Benefits - Drugless relief of presenting symptoms and improved balance of bodily energies which may lead to prevention and elimination of presenting problems.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by the ORIENTAL ACUPUNCTURE AND THERAPY CLINIC, INC. or any of its personnel regarding cure or improvement of my condition. I hereby release EDWARD Z. SALOMA from any and all liabilities which may occur in connection with the above procedures, except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw my consent and to discontinue participation in this procedure at any time.

Form notifying the acupuncturist of whether he/she has been evaluated by a physician and other information.

(Pursuant to the requirements of 22 T.A.C. §183.7 OF THE Texas State Board of Acupuncture Examiners' Rules (relating to Scope of Practice) and Tex. Occ. Code Ann., §205.351, governing the practice of acupuncture.)

I am allowing the acupuncturist, ***EDWARD Z. SALOMA,*** of the following:

__ ***Yes*** __ ***No*** I have been evaluated by a physician/dentist for the condition being treated within 12 months before the acupuncture was performed.

* I recognize that I should be evaluated by a physician/dentist for the condition being treated by the acupuncturist.

__ ***Yes*** __ ***No*** I have received a referral from my chiropractor within the last 30 days for acupuncture.

* After being referred by a chiropractor, if after two months or 20 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist has referred me to see a physician. It is my responsibility and choice whether to follow his advice.

APPOINTMENT CANCELLATION POLICY AGREEMENT

Oriental Acupuncture & Therapy Clinic, Inc. is committed to providing all of our clients with exceptional care. Because of our individualized assessment, health teaching and treatment, we are only limited to seeing 6-7 clients per day. When a patient cancels without giving enough notice, they prevent another patient from being seen.

Please call us at (915) 351-9444 by 2:00 p.m. on the day prior to your scheduled appointment to notify us of any changes or cancellations. **To cancel a *Tuesday* appointment, please call our office by 2:00 p.m. on *Saturday*.** If prior notification is not given, **you will be charged the whole amount** for the missed appointment.

Please sign below to consent to these terms.

_____ **Edward Z. Saloma**

Patient's Signature Above Printed Name — Acupuncturist's Signature Above Printed Name

Date: _____ Date: _____

Do not write here. This page is for the acupuncturist only.

INITIAL ASSESSMENT FORM

QF OP NP

Name: _____ Date: _____

Chief Complaint/s: Date of Onset:

_____ _____
_____ _____
_____ _____
_____ _____

What caused the problem/s?

_____
_____

What makes it better? _____
What makes it worse? _____

Pain:
Quality: _____
What makes it better? _____
What makes it worse? _____

Energy Level:

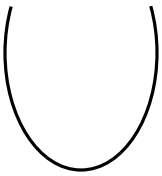
0 1 2 3 4 5 6 7 8 9 10

Headache, Dizziness: _____
Temperature: Hot / Cold; Fever / Chills _____
Thirst: _____
Perspiration: _____
Appetite: (Lack / Excess Appetite, Unusual Taste) _____
Digestion: (Heartburn, Belching, Gas, Bloating)_____
Bowel Movement: (Hard, Dry stools, Watery / Unformed, etc.) ____
Urination: _____
Eyes: _____
Nose:_____
Ears:_____
Mouth, Lips, Throat: _____
Chest / Abdomen_____
Number of Hours of Sleep: _____ Time of Sleep: _____
Dream-disturbed: _____
Sexual Function: _____
Menstruation: ___ Irregular ___ Clots ___ Breast distention
Length of cycle: _____ Length of menses:_____
Emotions:_____ Others: _____

OBSERVATION:

Facial Color (Shen):_____
Posture:_____
Palpation: _____
Pulse: Right: _____ Left: _____
Points: _____

Tongue: _____
_____
Underside Veins: _____
_____
Others: _____



Diagnosis: _____
_____
Tx Principles: _____
_____
Points: _____
_____
Herbs: _____
_____

Do not write here. This page is for the acupuncturist only.

FOLLOW-UP TREATMENT RECORD

Name: _____ Date: _____

Date of Previous Session: _____ Session #: _____

Age: _____ Sex: _____ BP: _____ LMP: _____

SUBJECTIVE:

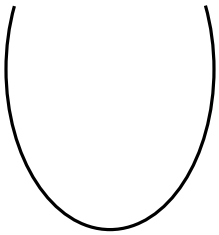
Main Complaint/s: _____
_____
_____
_____
_____

Diagnosis: _____
_____
Tx Principles: _____
_____
Advice: _____
_____
Herbs: _____
_____
Comments: _____
_____
_____

OBJECTIVE:

Tongue:

Body color: _____
Coating: _____
Shape: _____



Pulse: Position R

Quality: _____
Strength: _____
Rate: _____

1
2
3

Appearance / Palpation	**Points / Technique**

Herbs/Food Supplements Recommended:

_____
_____
_____