CONSENT FORM FOR TRADITIONAL MODE OF TREATMENT

I, the undersigned hereby authorize EDWARD Z. SALOMA, the Acupuncturist of ORIENTAL ACUPUNCTURE & THERAPY CLINIC, to perform 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.

**Plum Blossom or Seven Star Hammer** - A light tapping of an area of the body with a small hammer which has seven points.

**Gua Sha** - A rubbing of an area of the body with a blunt, round instrument.

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

**Wonder Cookie** - The heating of an herbal wafer and placing this wafer on an area or acupuncture point to gently warm it.

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

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.

**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 & THERAPY CLINIC 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.

**PATIENT’S SIGNATURE / AUTHORIZED PERSON TO CONSENT**

**DATE**

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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, (patient’s name) ____________________________________________, am allowing the acupuncturist, EDWARD Z. SALOMA, of the following:

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

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

Patient’s Initial: _____    Date: _______________

__ 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 is required to refer me to a physician. It is my responsibility and choice whether to follow this advice.

Patient’s Signature: ___________________________    Date: _______________

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(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.)

The acupuncturist has referred me to see a physician. It is my responsibility and choice whether to follow his advice.

Patient’s signature: ___________________________    Acupuncturist’s signature: ___________________________

Date: _______________    Date: _______________
Name / Nombre: __________________________ Date / Fecha: ________________

Age / Edad: __________ Sex / Sexo: ________ Height / Estatura: ________ Weight / Peso: ________

Blood Pressure / Presión: ____________________ Occupation / Ocupación: ____________________

Main Complaint/s // Malestar principal:

Date of Onset // Fecha en que inició: ______________________________________________________

What caused it // Que lo causó? __________________________________________________________

What makes it better // Que lo mejora? _____________________________________________________

What makes it worse // Que lo empeora? ____________________________________________________

Pain // Dolor:

Quality // Descipción: _________________________________________________________________

What makes it better // Que lo mejora? _____________________________________________________

What makes it worse // Que lo empeora? ____________________________________________________

Energy Level // Nivel de energía:

Very low Muy bajo 1 2 3 4 5 6 7 8 9 10 Maximum Máximo

(To be filled up by the Acupuncturist)

Headache, Dizziness / Dolor de cabeza, Mareos: ____________________________________________

Temperature: Hot / Cold; Fever / Chills; Thirst // Temperatura: Caliente / Frío; Fiebre / Escalofríos; Sed: _____________________________________________________________

Perspiration / Sudores: _________________________________________________________________

Appetite: (Lack / Excess Appetite, unusual Taste) // Apetito: (Excesivo, Poco o Sabores Unusuales): ________________________________________________________________

Digestion: (Heartburn, Belching, Gas, Bloating) // Digestion: (Agruras, Eruptos, Gases, Inflamación): __________________________

Bowel movement: (Hard, Dry stools, Watery / Unformed, etc.) // Excremento: (Duro, Seco, con Agua / sin Forma, etc.): __________________________

Urination // Orina: ________________________________________________________________

Eyes // Ojos: __________________________________________________________ Nose // Nariz: __________

Ears // Oídos: __________________________________________________________ Mouth, Lips, Throat // Boca, Labios, Garganta: __________________________

Chest / Abdomen // Pecho / Abdomen: __________________________________________________

Sleep / Sueño: Number of hours // Numero de horas: __________ Dream-disturbed // Disperta en las noches, etc. __________________________

Sexual Function // Función sexual: ______________________________________________________


Length of cycle // Duración del ciclo: ______________ Length of menses // Por cuantos días: ______________

Emotions // Emociones: ________________________________________________________________

Others // Otro: ________________________________________________________________

OBSERVATION:

Facial Color (Shen): ____________________________________________________________

Posture: ____________________________________________________________ Underside veins: ______________

Palpation: ____________________________________________________________

Pulse: R-_________ L-_________ Points: ______________________________________________

Others: ________________________________________________________________

DIAGNOSIS: ________________________________________________________________

TX PRINCIPLE: ________________________________________________________________

POINTS: ________________________________________________________________

HERBS: ________________________________________________________________

EDWARD Z. SALOMA: __________________________