Welcome to

ORIENTAL ACUPUNCTURE & THERAPY CLINIC, INC.

"Natural Treatment for Pain, Cancer, etc." "The Fountain of Youth"

4026 Suite E. N. Mesa (Centro El Rincon) El Paso, Texas 79902
Behind Como's Italian Restaurant, Corner of N. Mesa St. and Waymore Dr.
Text or Call: (915) 351-9444 ***www.orientalacupunctureelpaso.com***

GENERAL REMINDERS

By appointment only.
A Registration Fee of $25 must be paid before confirming a slot. It is non-refundable but can be transferrable if proper rescheduling protocol was followed. (Refer to *Payment Options* below)
Fill out this Assessment Form completely and bring it with you on the day of your appointment.
We open our door at 8:30 am and come back after lunch break at 1:30pm.
If your appointment falls on these specific hours, just come on time or please wait patiently at the parking area.
To avoid crowding inside the clinic and follow social distancing protocols, please come at least 10 minutes earlier.
Eat a good solid meal at least 1 - 2 hours before your scheduled session.
The needles re-channel the body's internal energy.
Poor or lack of energy may cause the body to weaken, collapse or faint.
If this happens, the session will be discontinued but the full session fee will still be charged.
Wear a comfortable, non-restricting clothing. You can also bring your own shorts or loose pants.

FULL SESSION includes the following:

1. Objective and Subjective Assessment (Assessment Forms, Medical Forms and Physical Assessment)
2. Personalized Health Teaching (Health Modification Guide)
3 Acupuncture (20-40 minutes), (Can address up to 5 to 8 health problems)
4. Therapeutic Massage (To relax the body, release tensions and blockages and promote better circulation).

(Approximately 40 minutes to 1 hour and 15 minutes maximum) (case to case basis)

FIXED FEES AND RATES:

Reservation Fee	$ 25.00
Initial / First Visit (Full Session)	$ 125.00
Follow-up / Regular Visit (Full Session)	$ 100.00
Auricular / Ear Pellets	$ 20.00

(If the Reservation Fee was paid in advance, it will be deducted from the total balance upon check out.)

Supplements and other Miscellaneous items are sold separately.

APPOINTMENT CANCELLATION POLICY

When cancelling an appointment, we require all clients to provide **MORE than 48 hours notice** to the scheduled time.

For those with Tuesday appointments:
The clinic is closed every Sunday & Monday, please inform us at least 3 days earlier (the Saturday before), not later than 2 pm to give way to other patients.

Arriving 15 minutes late without proper valid notice to the receptionist Is considered a "No Show".

Arriving late but still within 15 minutes, means that your session will still be continued but shortened.
Full payment fee will still be charged.

The management can only afford to give (3) warnings and has the right to refuse service to anyone for any reason.

PAYMENT OPTIONS

Cash, Personal Check, Gift Certificate

Zelle Edward Saloma (915) 373-5323

Pay (915) 351-9444

All Major Credit & Debit Cards
(+3.5% processing fee)

venmo

CashApp

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Quick Fix *Old* *New*

Date: _____
Time: _____

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: _____

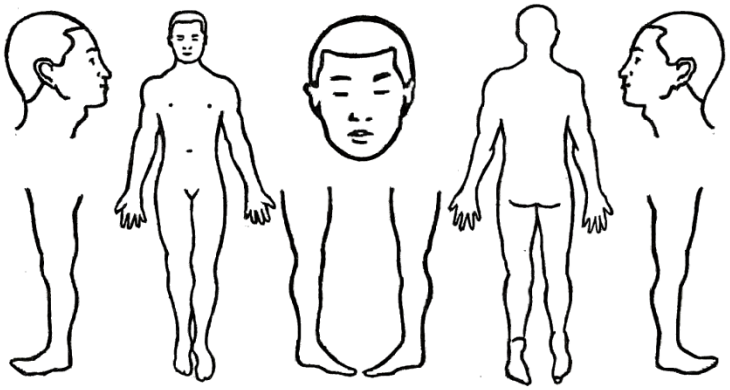
Referred by: _____

SUBJECTIVE INFORMATION

Health Problems: **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: (When you were born)

___ Normal Delivery ___ Forceps Delivery
___ Prolonged Labor ___ C-Section
___ Pre/Post Mature 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/Specify what consists of your average meals:

(Example: Apple, Salad, Brown Rice, Chicken, Fish , 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: _____
_____

RESPIRATORY

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

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: _____
_____

HEAD, EYES, EARS, NOSE, THROAT

__ Dizziness
__ Migraines
__ Headaches
When? _____
Where? _____
__ Facial pain
__ Eyeglasses
__ 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: _____
_____

SKIN AND HAIR

__ Rashes
__ Itching
__ Change in hair / skin
__ Ulcerations
__ Eczema
__ Oozing in skin lesions
__ Hives
__ Pimples
__ Recent moles
__ Loss of hair
__ Dandruff

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.

Tui Na 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.

Massage: The manipulation of the body's soft tissues generally for the treatment of body stress, tension or pain.

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 theTexas 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

Our business operates on a scheduled appointment basis. When cancelling an appointment, we require all clients to provide **MORE than 48 hours notice** to the scheduled time.

For those with **TUESDAY APPOINTMENTS,** please inform us **3 DAYS EARLIER** (the Saturday before)**,** because we do not work on Sunday and Monday, at least before 2 pm to give chances to those who are on the waitlist.

The **Appointment Reservation Fee ($25) is Non-Refundable** but may be Transferrable (rescheduling protocol should be followed)
For more in-depth details regarding the rules on **Late Cancellations and Late Arrivals** please refer to the website.

The management can only afford to give three **(3) warnings for habitual offenses** and has the **right to refuse service** to anyone for any reason.

Please sign below to consent to these terms.

_____
Patient's Signature

_____
Printed Name

Date: _____

Edward Z. Saloma
Acupuncturist's Signature Above Printed Name

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:

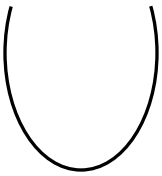
0 1 2 3 4 5 6 7 8 9 10

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: _____
_____

_____
Edward Z. Saloma

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

FOLLOW-UP TREATMENT RECORD

Name: _____ Date: _____

Date of Previous Session: _____ Session #: _____

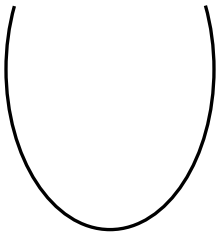
Age: _____ Sex: _____ BP: _____ LMP: _____

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:

_____
_____
_____

OATCAF2022

Edward Z. Saloma