



# ORIENTAL ACUPUNCTURE & THERAPY CLINIC, INC.

4026 N. Mesa (Centro El Rincon) Suite F. El Paso, Texas 79902

Clinic: (915) 351-94444

www.orientalacupunctureelpaso.com

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 (page 3)

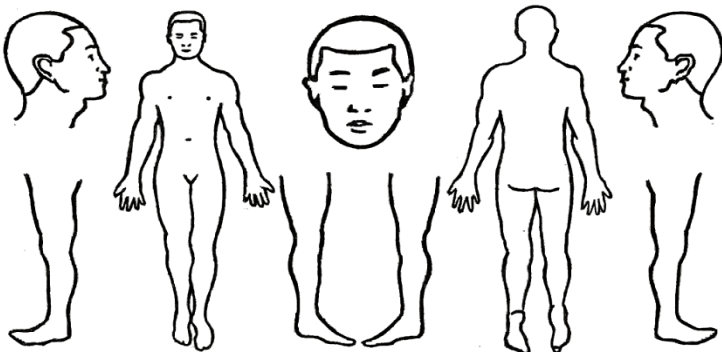
## PERSONAL INFORMATION

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: \_\_\_\_\_

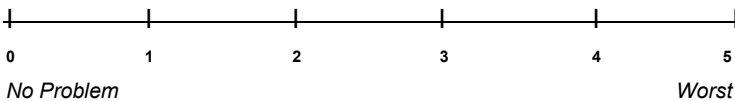
## SUBJECTIVE INFORMATION

Main problem/s: \_\_\_\_\_ Date of Onset: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Shade Affected/Distressed Areas:



Rate the Severity of the Problem:



Other of Mode of Treatments Tried:

\_\_\_\_\_  
\_\_\_\_\_

## PAST MEDICAL HISTORY

When you were born:  
\_\_\_ Normal Delivery                      \_\_\_ Forceps Delivery  
\_\_\_ Prolonged Labor                    \_\_\_ Caesarean 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?  
Vitamins: \_\_\_\_\_  
Herbal Supplements: \_\_\_\_\_  
Maintenance Drugs: \_\_\_\_\_  
Others: \_\_\_\_\_

Describe your average meals: (Please don't leave blank)  
Breakfast: \_\_\_\_\_  
Lunch: \_\_\_\_\_  
Dinner: \_\_\_\_\_

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

Water Intake within 24 hours? \_\_\_\_\_

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.

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:

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. \_\_ 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. \_\_ Yes \_\_ No

## 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.

\_\_\_\_\_  
Patient's Signature Above Printed Name

Date: \_\_\_\_\_

**Edward Z. Saloma**

\_\_\_\_\_  
Acupuncturist's Signature Above Printed Name

Date: \_\_\_\_\_