



ORIENTAL ACUPUNCTURE & THERAPY CLINIC

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

(915) 351-94444 / (915) 373-5323 www.orientalacupunctureelpaso.com

Date: _____

Time: _____

IMPORTANT REMINDERS

By appointment only.
Fill out the form completely and come at least 15 minutes before your designated time (except for 8:30am and 1:30pm appointments)
Eat a solid meal 2 hours before your scheduled session.
Wear a comfortable, non-restricting clothing.
For cancellation, call the clinic 24 hours before your appointment.

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: _____

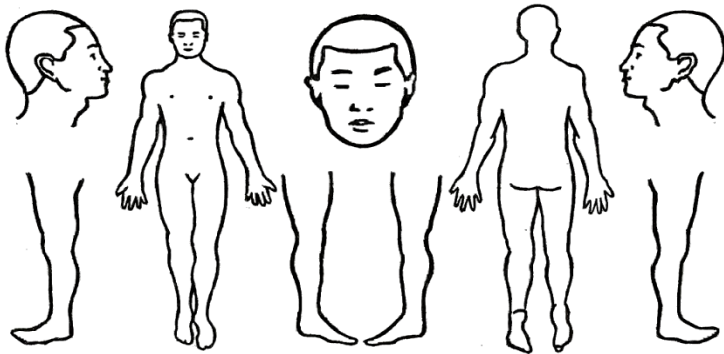
Family Physician: _____

Referred by: _____

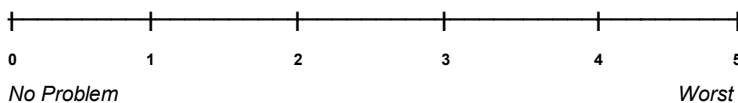
SUBJECTIVE INFORMATION

Chief Complaint/s: _____ Date of Onset: _____

Indicate 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 daily meals:

Breakfast: _____
Lunch: _____
Dinner: _____

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

Water Intake within 24 hours? _____

Estimated weekly intake of other beverages:

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**, 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.

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 AND 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.

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

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

Edward Z. Saloma

Patient's Signature Above Printed Name

Date: _____

Acupuncturist's Signature Above Printed Name

Date: _____