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| YOUR INFORMATION  |  |  |  |  |  | | --- | --- | --- | --- | --- | | First name / 名 : | Last Name / 姓 : | | | | | Birth date / 生年月日: | | Age / 年齢: | Sex / 性別: | |  | |  |  |   Address / 住所:   |  |  |  | | --- | --- | --- | | Phone No. / 電話番号: | Work phone no. /お仕事の電話: | Mobile no. / 携帯電話: | |  |  |  |  |  |  | | --- | --- | | How did you hear about the Practice? / ご紹介者又はどのように当院をお知りになりましたか？ |  |   Pharmaceutical Medications (Please list those you are currently taking) / 現在服用中の薬名をお書きください   |  | | --- | | What is/are your main complaint(s)? / 主訴（つらい所はどこですか？いつ頃からですか？） | |  |   Medical history (Surgeries/Hospitalisation/Injuries) /病歴（手術、病気、ケガ） INFORMED CONSENT FOR TREATMENT: Please read and agree to our terms conditions治療への同意: 必ずお読みの上同意願います I hereby request and consent to the performance of acupuncture treatment, massage treatment, manual therapy and other related procedures, including physical examinations, the use of acupuncture needles and modalities of heat (moxibustion), massage on myself (or the patient named below, for whom I am legally responsible). Though treatments and therapies are usually beneficial and seldom cause any problems at all, I understand and am informed that as with any medical treatments there are risks involved.  鍼灸治療、マッサージ、徒手療法又はそれらに関連する身体検査を受けること、鍼や灸の使用に同意致します。またこれらの療法、治療は通常効果があり、健康に害を及ぼすものではありませんがリスクを伴うことを理解しました。    Patient signature / 患者の署名: Date:  Guardian signature / 保護者の署名（患者が未成年者の場合): Date:  Practitioner signature /セラピストの署名: Date: |