WELCOME TO MY OFFICE!

Thank you for choosing my office. My purpose is to assist each individual in achieving his/her optimum health. I look forward to providing for your health needs, emphasizing preventative care and health maintenance. Traditional Chinese Medicine, which primarily includes Acupuncture and Chinese Herbs, offers an approach that may differ from other methods, but is very complementary to other medical approaches.

In order to serve you properly, I will need the following information. Please print and answer all questions completely. All information will be strictly confidential.

Name:____Date:__________________________
Address:____Age:_________DOB:______________
City/State/Zip:_____________________________________Phone:_________________________
SS#:_____________________Marital Status: Single Married Divorced Partner Widowed
Employer:____Occupation:____________________
Work Address:______________________________________Phone:_________________________
City/State/Zip:____
Emergency Contact:_____________________Relation:_________________Phone:_____________
Referred by:____Relation:______________________

I voluntarily consent to be treated with Acupuncture by Shinichi Moriyama, Licensed Acupuncturist.

I understand that Acupuncture is performed by the insertion of needles. This occurs through the skin and/or by the application of heat to the skin at certain points on or near the surface of the body. The effect of Acupuncture is to treat bodily dysfunctions or diseases, to modify or prevent the perception of pain, and to make normal the body's physiological functions. I have been informed that only disposable needles will be used during each treatment.

I have been made aware that certain adverse side effects may result. These could include, but are not limited to, some local bruising, minor bleeding, fainting, temporary pain or discomfort, and the possible temporary aggravation of symptoms existing prior to Acupuncture treatment.

I am also aware that Acupuncture is licensed in Oregon and many other states, that Acupuncture has been safely practiced for centuries, and that the FDA classifies the procedure as a medical procedure. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop Acupuncture treatments at any time.

I have carefully read and understand all of the above information, and I am fully aware of what I am signing.

____ ______________________

Signature (Patient/Parent/Guardian) Date