Medical Information Sheet (confidential)　　Date：＿＿＿＿／＿＿＿＿／＿＿＿＿

Name		Male・Female
Date of Birth	Age:	
Nationality		
Address		
Phone	Home：☐Prefer not to be contacted Cellphone：☐Prefer not to be contacted	
Email		
Written by	☐Self ☐Other： Name　　(Relationship：　　)	

To help us understand your condition, we would like to ask some questions. If you prefer not to answer some questions, please leave them blank. If you are not sure, please ask.

☕ How did you find this clinic? Please put checkmark (s).

☐Introduced by other hospital/facility (Name:　　)

Do you have a letter of reference? ☐Yes　☐No

☐Introduced by other (Who:　　)　☐See a poster (Where:　　)

☐From website (Research word:　　)

☐Other (　　)　☐Just walked by

☕ What is your reason of visiting this clinic? Please put a checkmark.

☐Have problem(s) you would like to solve　☐Recommended by family / friend / coworker

☕ What kind of problem(s) do you have?

☕ Since when do you have the problem? Why?

Since year:_____ Month:_____(Age:)

Reason:

☕ How is your condition since then?

☐Getting better ☐Have not change ☐Getting worse ☐Depends on the day

☕ Have you visited other hospital/facility? ☐ No

☐Yes. (Please describe E.g., ○○○○Hospital, April, 2017～January, 2018)

☕ Which symptom(s) do you have? Please put checkmark(s).

☐Cannot fall asleep ☐Cannot staying asleep ☐Waking up too early

☐Poor sleep quality ☐Over sleep

☐Faint / Lose consciousness

☐Feel depressed ☐Do not feel energetic ☐Get tired easily

☐Scattered thoughts ☐Cannot think in orders

☐Keep repeating same thoughts in the head ☐Cannot relax

☐Feel anxious (When?)

☐Feel impatient ☐Racing heart ☐Feel suffocating

☐Thinking about death ☐Thinking often about suicide ☐Committed suicide

☐Hurt yourself ☐Hurt somebody else ☐Feel irritated ☐Feel anger ☐Feel too energetic

☐Distracted easily ☐Cannot go outside

☐Looked down/teased by others ☐Cannot talk with others properly

☐Headache ☐Stiff shoulder ☐Feel sick ☐Feel dizzy ☐Diarrhea ☐Constipation

☐Lost body weight ☐Gained body weight ☐Eat too much ☐Throw up after eating

☐Drink too much ☐Cannot stop even you want to (What?)

☐Premenstrual syndrome (PMS) ☐Irregular menstruation ☐Sexual dysfunction

☐Other:

*Name*_____

Have you ever tried medication from psychiatry?

☐Yes, and still do. ☐Yes, used to and not anymore ☐No

Medicine that worked well:

Medicine that did not work /caused side effect:

Have you ever had any major illness/injury before? When? ☐No

☐Yes (Please describe)

Are you currently under medical treatment? Since when? Any medication? ☐No

☐Diabetes

☐High blood pressure

☐Pollen allergy

☐Pregnant / Possibility of pregnancy / Currently Breastfeeding

☐Any other sickness (Please describe)

Do you have any food/medicine allergy? ☐No

☐Yes ▷ What allergy? :

What happened?

Do you drink alcohol? ☐Never/Barely ☐Occasionally

☐Almost everyday (_____ml/day Drink:_____)

Do you smoke cigarettes? ☐No ☐Yes (_____/day, since age: _____)

Have you tried huffing paint thinner, marijuana, illegal drug, crack etc? ☐Yes ☐No

Please let us know your personal history.

Your relationship status is

☐Single ☐In relation ☐Married (Age:_____) ☐Divorced (Age:_____)

☐Remarried (Age:_____) ☐Widow/widower (Age:_____)

☐Living Alone ☐Living with somebody else: With:

Education background: You have ▷ ☐Graduated from ☐Withdraw from ☐Enrolling in

☐Middle school ☐High school ☐2-year Community college

☐4-year Collage/University ☐Graduate school

Name of school:_____

Please write your work history:

(E.g., 22 y.o. ～ 26 y.o. at retail store)

Are you currently taking a break from work? ☐No

☐ Yes (Since when?)

Do you have any of the following?

Insurance in Japan ☐No ☐Yes

Disability certificate ☐No ☐Yes

Livehood protection ☐No ☐Yes

Others:

Please tell us about your family. If the member has passed away, please put a checkmark.

Father: Age _____ Occupation _____ ☐

Mother: Age _____ Occupation _____ ☐

Brother / Sister: Age _____ Occupation _____ ☐

Brother / Sister: Age _____ Occupation _____ ☐

Brother / Sister: Age _____ Occupation _____ ☐

Child: Male/Female Age _____ Occupation _____ ☐

Child: Male/Female Age _____ Occupation _____ ☐

Child: Male/Female Age _____ Occupation _____ ☐

Have your family/relatives got diagnosed with any mental/psychological problem? ☐No

☐Yes (Please describe. E.g., Mother-side uncle with depression.)

Do you have any other comment or request?

Thank you,