Notes for the Medical Questionnaire

You can use this medical questionnaire only after your appointment has been confirmed.
If you have not booked yet, please make a reservation through the online form.
Consultations in English are available only for patients who are 18 years or older.

～For patients with a confirmed appointment～

If possible, please print and fill out the form at home before your visit.
If that is not convenient, you can also complete it at the clinic on the day of your appointment. In that case, we kindly ask you to arrive a little earlier than your scheduled time.

The medical questionnaire begins on the next page.

Medical Questionnaire

Name（　　）　**Full Name:**（　　）
Gender: (Male ・ Female・ Nonbinary)
Date of Birth: (Year　/ Month　/ Day　) **Age:**（　years)
Address:（　　）
Phone Number:（　－　－　）　**Emergency Contact:**（　－　－　）
Health Insurance:（　　）

---

① What are your symptoms?
Please check all symptoms that apply.

1. Trouble sleeping (difficulty falling asleep / waking up many times / waking up early)
2. Mood changes (feeling depressed / sad / easily irritated / overly energetic)
3. Poor appetite, cannot eat
4. Overeating
5. Panic attacks
6. Difficulty managing work
7. Difficulty with relationships
8. Feeling people are talking badly about you or watching you
9. Paranoid thoughts
10. Hearing voices when no one is there
11. Suicidal thoughts
12. Fear of harming yourself
13. Others: (　　)

Please describe in detail your symptoms, when they began, possible triggers, and what troubles you most.

---

② Past psychiatric treatment
If you have ever received treatment (outpatient or inpatient) at psychiatry/psychosomatic medicine:

From (Year/Month/Age)	To (Year/Month/Age)	Hospital/Clinic

Diagnosis:（　　）
Treatment:（　　）

③ Past illnesses or injuries

Please check all that apply:

- Hypertension
- Diabetes
- Asthma
- Heart disease (　　)
- Liver disease (　　)
- Stroke (　　)
- Injuries (　　)
- Epilepsy
- HIV
- Other (　　)

④ Current medications

Do you take any medications?

☐ No　☐ Yes → Please list:

- Medication (　　) (　　tablets) (Morning / Noon / Evening / Bedtime)
- Medication (　　) (　　tablets) (Morning / Noon / Evening / Bedtime)
- Medication (　　) (　　tablets) (Morning / Noon / Evening / Bedtime)
- Medication (　　) (　　tablets) (Morning / Noon / Evening / Bedtime)

⑤ Allergies

Do you have any allergies?

☐ No　☐ Yes → Please specify:

- Medication: (　　)
- Food: (　　)
- Pollen / Alcohol / Other: (　　)

⑥ Lifestyle habits

- Alcohol: ☐ Do not drink ☐ Drink (　　ml/day,　since age:　　)
- Tobacco: ☐ Do not smoke ☐ Quit ☐ Smoke (　　cigarettes /day,　since age:　　)
- Drugs: ☐ Never used ☐ Previously used (please specify:

⑦ For women

Are you currently pregnant?

☐ Yes　☐ No　☐ Possibly

⑧ Personal background

Place of birth: (　　)

Education:

- Elementary school (Public / Private) graduated
- Junior high school (Public / Private) graduated
- High school (Public / Private) graduated / dropped out
- University / Junior college / Vocational school　Faculty:　　Department:　(Graduated / Dropped out / Currently enrolled)
- Other: (　　)

Work/Part-time job history:

- Around age (　): (　　)
- Around age (　): (　　)
- Around age (　): (　　)
- Around age (　): (　　)

---

⑨ Family background

Marital history: ☐ None　☐ Yes (Times:　/ Currently: Married・Divorced・Widowed)

Family living together:

Name	Relationship	Age	Occupation / School grade

Family not living together:

Name	Relationship	Age	Occupation / School grade

---

⑩ Did you come here voluntarily?

☐ I came on my own voluntarily

☐ Recommended by a family member / friend / colleague / other (　　)

Accompanied by someone today?

☐ No　☐ Yes (Name:　　Relationship:　　)

⑪ How did you learn about our clinic? (Check all that apply)

Referral:

☐ Friend　☐ Company staff

☐ Hospital/Clinic (Name:　　Referred by:　　)

☐ Pharmacy (Name:　　)

☐ Other facility (　　)

Internet:

☐ Medical search site (Site name:　　)

☐ Introduction article / Interview with our director (e.g., Medical Doc, Yahoo News, Doctor's File, YomiDoctor, Other:　　)

☐ Our website (Search word used:　　)

Other:

☐ Passed by near our clinic

☐ Publication (Book title:　　)

☐ Other (please specify:　　)