



受診日 平成 _____ 年 _____ 月 _____ 日 ID _____

御予約時間 _____ :

• MRI • CT • XP
• 紹介状

Please fill out the form below

Name _____ Date of Birth _____ year _____ month _____ day (_____ years old)

Address 〒 _____ Phone _____

Do you have health insurance? Yes No Nationality _____

How did you hear about this facility? Height _____ cm Weight _____ kg

(A neighborhood • Web • Signboard • Rumor • Referred (Introducer : _____))

Occupation _____

Student _____ grade _____

1. Where do you have problems? _____

Please circle the affected area(s) in the diagram on the right

2. When did the symptoms start?

Since approximately: _____ year _____ month _____ day

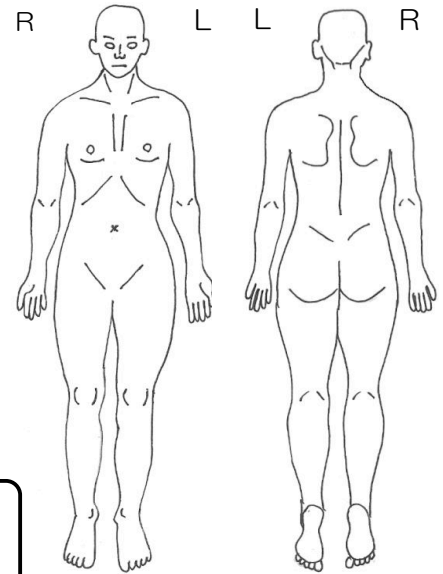
3. What kind of symptoms? (Please check this box)

pain numbness heavy swelling

deformity instability weakness

bad motion other (_____)

4. What was the cause?



5. When do you have symptoms? (Multiple answers allowed)

always compression at night

movement (How? _____) other (_____)

6. How are your symptoms since the problem started?

getting better getting worse no change coming and going other (_____)

7. About your exercise

no exercise due to symptoms can exercise with symptoms usually don't exercise

8. History of treatment

Hospital (_____) (Dr. _____) diagnosis (_____)

treatment (cast • operation • medicine • injection • rehabilitation • other (_____)

Please fill in the reverse side of the all pages as well, where necessary

【Have you ever had any particular illness or surgery? 】

No Yes

Diagnosis (_____) When? (_____) year Hospital (_____)

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【Allergy】 No Yes (_____) **【pregnancy】** No Yes (Now _____ month)

【Dominant Hand】 Right Left **【Batting】** Right Left **【Kick leg】** Right Left

【Sports history】	grade	sports	position	# of practice
Elementary school	___ ~ ___	_____	(_____)	_____ day/week
Junior high school	___ ~ ___	_____	(_____)	_____ day/week
High school	___ ~ ___	_____	(_____)	_____ day/week
University	___ ~ ___	_____	(_____)	_____ day/week
Now	_____	_____	(_____)	_____ day/week

【Sports that you wish to play in future】

Competition Recreation No sports

【About your treatment】

1. **Request to this clinic** (Multiple answers allowed)

Diagnosis Medicine An operation

Receive rehabilitation Learn training methods Second opinion

2. **Future treatment** Receive treatment at this clinic Only second opinion

3. **How many times do you want to have rehabilitation?**

Once a week Twice / Three times a week

4. **How will you pay for treatment?** Health insurance Own expense

5. **Do you want to receive personal training at the Medical Fitness Center, if necessary?**

Yes No

6. **Do you want to receive sports massage, acupuncture, acupressure, O₂ capsule or bedrock bath?**

Yes No

【About the disclosure of personal information】

The patient' s data (including blood tests and imaging studies) will be need for the analysis and information share in the institution. In addition, we may use data of patients for a research paper.

Thank you for your cooperation. The doctor will be with you shortly.