Hachioji Sports Clinic Medical Questionnaire Form

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

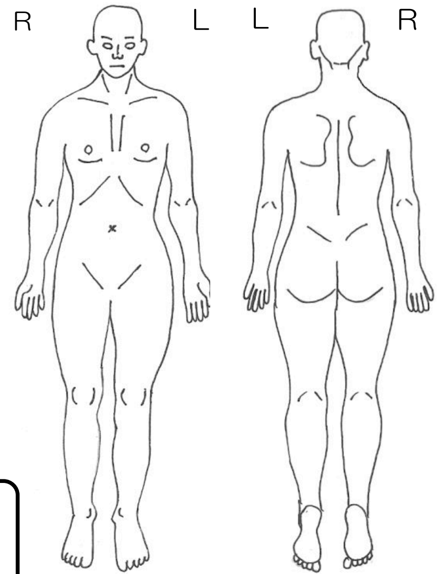
（A neighborhood ・ Web ・ Signboard ・ Rumor ・ Refered （Introducer：＿＿＿＿＿＿＿））

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 (________________)

Diagnosis (________________) When？ (______) year Hospital (________________)

【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, O_2 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.