

**For Patients Visiting the Department of Psychosomatic Medicine**

|  |  |
| --- | --- |
| Name : | Age : |
|  Sex： Male ・ Female | Marital status: Married / Single/ Divorced/ Bereavement |
|  Email address : | Tel： |

# Specify the issues you currently face. \*Place them in order, from the biggest issue first.

①

②

③

④

⑤

Others

# Provide background information on the symptoms of the above problems.

**(Give details such as when the symptoms started and under what circumstances, any changes in the symptoms, history and results of treatment.)**

1. **Have you had any previous serious illness surgery or have you been hospitalized before?**

Age Illness Hospital where you Details of treatment Results of treatment

have been treated

1. **Do you have any allergies?** YES ・ NO

Medication Food

# List any medications you are currently taking.

1. **Complete the following about the structure and medical history of your family.**

**\*Include yourself and any brothers or sisters.**

Grandfather Grandmother Grandfather Grandmother

Father

Mother

Relationship with anyone who has the following illnesses

High blood pressure （ , ）

Stroke （ , ）

Heart disease （ , ）

Cancer （ , ）

Diabetes （ , ）

Asthma （ , ）

**\* Who was primarily responsible for your upbringing?** (Father / Mother / Other )

# Daily routine

Time when you get up: Time when you go to bed: Time when you start work: Time when you finish work: Average working hours: hours Meals:\_\_\_\_\_\_\_\_times /day Appetite: good, poor

Smoking habit: cigarettes / day, never

Daily alcohol intake: whiskey, beer, wine, other ml / day, \_\_\_\_\_ times / week, never

Sport or regular exercise: Hobbies:

1. **During the past 4weeks, how much have you been bothered by any of the following problems ?**

|  |  |  |
| --- | --- | --- |
| Not bothered at all | Bothered a little | Bothered a lot |
| 1) Stomach pain | □ | □ | □ |
| 2) Back pain | □ | □ | □ |
| 3) Pain in your arms, legs, or joints (knees, hips, etc.) | □ | □ | □ |
| 4) Menstrual cramps or other problems with your periods(women only) | □ | □ | □ |
| 5) Headaches | □ | □ | □ |
| 6) Chest pain | □ | □ | □ |
| 7) Dizziness | □ | □ | □ |
| 8) Fainting spells | □ | □ | □ |
| 9) Feeling your heart pound or race | □ | □ | □ |
| 10) Shortness of breath Palpitations or quick pulse | □ | □ | □ |
| 11) Pain or problems during sexual intercourse | □ | □ | □ |
| 12) Constipation, loose bowels, or diarrhea | □ | □ | □ |
| 13) Nausea, gas, or indigestion | □ | □ | □ |
| 14) Feeling tired or having low energy | □ | □ | □ |
| 15) Trouble sleeping | □ | □ | □ |

# 9.What is your impression of your current situation? Please include any ideas you might have about possible factors that caused or triggered your symptoms.

(including stress arising from your living environment or personal relationships at home, school or work).

# How would you like things to change or to change things in the future?

**Thanks for your cooperation!**