

REGISTRATION FORM

ID (

) 平成 年 月 日

Name						M · F
Address	〒 -		Phone			Cell-phone
Date Of birth	yyyy/mm/dd	/	/	Age ()		
Occupation	Infant	Student	Housewife	Unemployed	Self-employed	Office worker (Company name Phone)

- What type of insurance do you have?
 national health insurance traffic accident workers compensation others ()
1. What is the problem? Please describe:
 2. When did the problem start? ()
 3. What's the pain related to? (Work related injury, Vehicle accident, Sport injury?...)
 ()
 4. Is your pain recurrent? If yes, In your opinion, what makes it so?

5. Would you like to have an MRI
6. Medical history: Please circle any health problem that you have or have had?
 (Diabetes / High blood pressure / Heart disease / Liver disease / Asthma / Rheumatism /
 Hepatitis B / Hepatitis C / pacemaker / Others:)
7. Are you taking any medicines now?
 Yes. Please specify (drug name) _____ (dosage) _____
 No
8. Do you have any allergies to medication?
 Yes. Please specify (drug name) _____ Not sure
 No
9. What type of treatment would you consider?
 rehabilitation operation injection medication others ()
10. Would you like an examination for osteoporosis? Yes No If necessary
11. Are you pregnant? Is there a possibility you may be pregnant? Yes No
12. Do you smoke? Yes. How often ___/day. starting age _____
 No
13. Do you exercise regularly? Yes. Please specify what kind of sport activity do you practice?

 No.
- Do you have any hobby? Yes. Please specify) _____
 No
14. How did you learn about our hospital?
 personal introduction internet magazine referral others ()
15. Do you have any specific questions to the doctor?
 Yes. Please specify: _____
 No.