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.