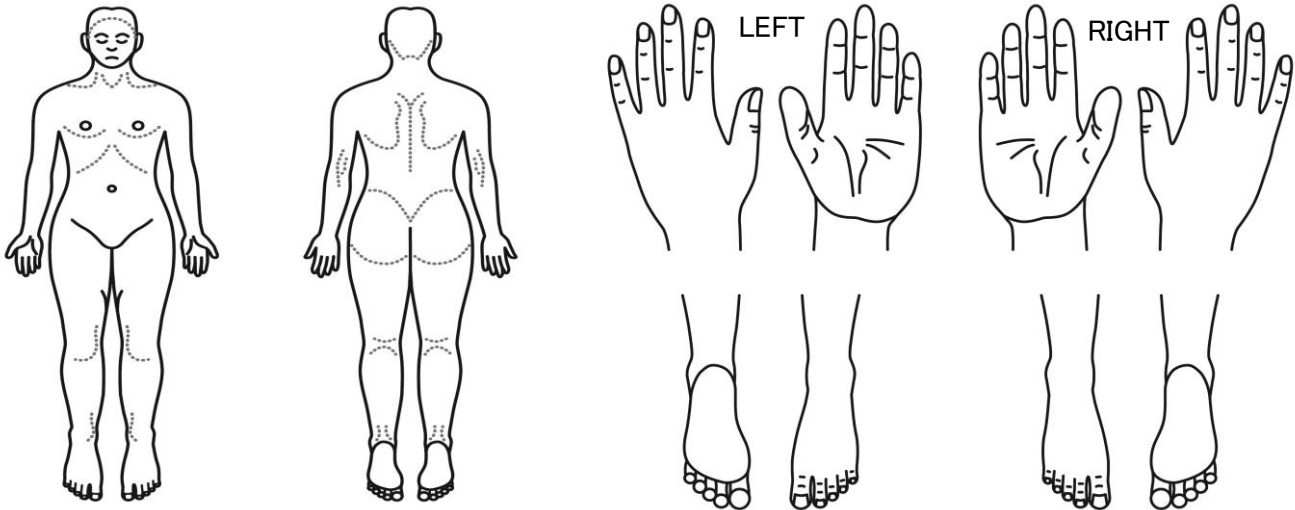


**PRELIMINARY QUESTIONNAIRE**



<b>Patient's</b>		<b>Date of visit</b>	
		year	month    day
<b>Family Name</b>	<b>First Name</b>	male	<b>Birthday</b>
		.	year    month    day
		female	<b>Age :</b>
<b>Address</b>	〒		
Do you have Japanese National Insurance (保険の有無)		<b>Phone No</b>	-    -
YES	NO	<b>Cellphone No</b>	-    -

**1. Which part of your body hurt ?** (あなたの体のどの部分ですか?)  
 Please circle the area of your pain, pictured below (下の絵に○をつけて下さい)



**Please Answer These Questions.** (これらの質問に答えて下さい)

- 2. When did the symptoms start?** (いつ症状が発症しましたか)  
 (      MM      DD      · a month ago    · three month ago    · over three month ago )
- 3. How did you get injured?** (どのような原因で負傷しましたか)  
 (traffic accident · work accident · commuting to / from work · other \_\_\_\_\_ )  
 (交通事故)                      (労働災害)                      (通勤)                                      (その他)
- 4. How is your harm?** (どのような症状ですか)  
 (swelling pain infection abrasion loss of feeling difficulty moving)  
 (腫れ・むくみ)    (痛み)    (化膿)    (擦過傷)    (感覚がない)    (移動困難)
- 5. Have ever had a serious illness?** (今までに大きな病気をしたことがありますか)      No    Yes (What?)      )
- 6. Do you see another physician?** (他の病院で受診していますか)      No    Yes (Where?)      )
- 7. Are you taking any medication?** (何かお薬を服用していますか)      No    Yes (Type?)      )
- 8. Do you have any allergies?** (アレルギーはありますか)      No    Yes (to What?)      )
- 9. Are you pregnant or have you resently had a child?** (妊娠又は授乳していますか)      No    Yes (pregnant probably pregnant breast feeding )
- 10. Did anybody introduce this hospital to you?** (当医院をどのように知りましたか)      No    Yes ( other hospital acquaintance family member other)
- 11. Have you received treatment here before?** (現在治療を受けていますか)      No    Yes (When?      Year      month)