Tanaka Clinic - Orthopedic Questionnaire

ID: Date (YYYY/MM/DD): / /

※If you have a medication record, referral letter, X-ray, or image CD, please hand it to the receptionist.

Name: Sex assigned at birth: (M / F) Date of Birth (YYYY/MM/DD): / /

Postal Code:

Address:

Phone Number

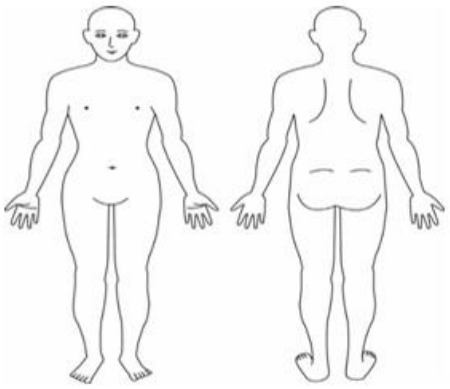
(Home) – –

(Mobile) – –

◆ What symptoms brought you to the clinic today?

Please describe:

Please circle the area(s) where you feel symptoms.



◆ When did these symptoms start?

◆ Please select the cause or trigger of your symptoms.

(Injury / Accident / Work (including commute) / Sports / Unknown)

Details of the situation:

◆ Have you received treatment for these symptoms elsewhere? (Yes / No)

If yes, please specify the facility and type of treatment:

◆ Are you currently receiving treatment for any illness? (Yes / No)

◆ Are you currently taking any medications? (Yes / No)

If yes, please list the names:

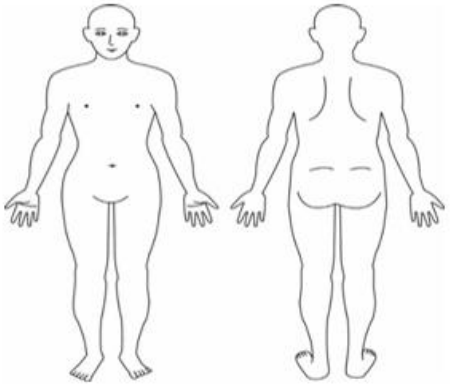
◆ Do you have any allergies? (Yes / No)

If yes, please specify (e.g., medications, foods):

◆ Have you ever had any major illness, injury, or surgery?

Please describe: (e.g., condition, body part, time period).

You may also mark the affected area(s) on the diagram.



◆ (Females only) Pregnant or possibly pregnant? (Yes / No)

If yes: (Pregnancy Week ___ / Not yet tested)

◆ Do you have long-term care insurance certification? (Yes / No)

Certification level: Care level:【 1 2 】Support level【 1 2 3 4 5 】 【Unknown】