Application for Medical Care

Name _____

Date of birth Year / Month / Day (Age:)

Address 〒 —

_____

Telephone _____

Mobile _____

E-mail @

_____

Secondary Contact Information*

Name:

_____

Telephone:

_____

Relationship:

_____

*We request that you kindly provide us with secondary contact information in case we need to contact you for emergency.

Consent Statement to Appointment Fee

I understand that Tokyo Neuro Center designated to provide appointment-based care charges the below appointment fee for medical care.

Dr. Matsui:	~~First visit~~	~~JPY20000~~	Follow-ups	JPY3000
Other Doctors:	First visit	JPY3000	Follow-ups	JPY1000

I hereby agree to pay the appointment fee for medical care.

Signature _____

Signature of Parent/Guardian _____

Tokyo Neuro Center

Q.2 How did you know our hospital ?
(if you are to circle more than one, please double-circle the first occasion.)

1. Book (title: 2. Magazine (title:)
3. Newspaper ( ) 4. TV (5. Radio ( ) 6. Internet ( )
7. Family/Friend/Acquaintance ( )
8. Others ( )

Q.3 Please check all the care providers you have consulted with/received care from.
Write the number of hospitals you have visited in ( ) and their diagnoses in 【 】.
Example: Neurosurgery (3) 【No abnormality found】

Neurosurgery	( ) 【 】		Otorhinology	( ) 【 】	
Orthopedics	( ) 【 】		Neurology	( ) 【 】	
Internal	( ) 【 】		Gynecology	( ) 【 】	
Gastroenterology	( ) 【 】		Psychosomatic	( ) 【 】	
Cardiovascular	( ) 【 】		Psychiatry	( ) 【 】	
Eye/Ophthalmology	( ) 【 】		Others	( ) 【 】	

Acupuncture/moxibustion (Oriental medicine) ( )
Chiropractics ( ) Massage ( ) Bonesetter ( )

Q.4 Have you ever had a head injury or whiplash? (Yes / No)
If yes, when did it happen? (Year: Month:)
Have you received traction therapy? (Yes / No)
Have you received nerve block treatment? (Yes / No)

Q.5 Do you ever feel so dull when you wake up in the morning that you have difficulty getting up? (Yes / No)

Q.6 Have you ever had an anxiety attack? (Yes / No)

Q.7 Have you ever had a blood patch? If you have, write down how many times.
(Yes / times / No)

Q.8 Do you experience unstable blood pressure? (Yes / No)
Please write down your blood pressure levels. (Highest:)
(Lowest:)

Q.9 Are you on antidepressants now or were you ever? (Yes / No)

If you are-were on antidepressants, please write down which antidepressants you are/were taking and when. Write all the medications you are currently on including antidepressants.

QUESTIONNAIRE FOR EXAMINATIONS

Name:	Date(Y.M.D) / /

Upon consultation with your doctor, you may be required to undergo a CT/MRI scan and/or a blood test.
Please be aware that you may not be able to undergo examinations due to your answers to this questionnaire.

■Circle the answer that best describes your conditions in each question below.

1, Have you ever had an MRI and/or CT before?

No Yes, I have had a (MRI/CT).

2, Have you ever had a surgery before?

No Yes

*If yes, please describe when and what kind of surgery you had.

Please notify the staff if you have a pacemaker, brain clips, coronary clips, a cochlear implant,a femoral head implant or any other prostheses/metal implants (you may be unfit for the examinations).

3, For female patients only, are you currently or possibly pregnant?

No Yes (month)

4, Have you ever been diagnosed with hepatitis or as a hepatitis virus carrier before?

No Yes (type)

5, Do you have claustrophobia (fear of being in closed or small spaces or rooms)?

No Yes

6, Do you have a tattoo/permanent makeup?

No Yes

Please read carefully the instructions below prior to the examinations.

■ INSTRUCTIONS

(1) Absolutely no metal object is allowed in the MRI room. Leave items such as the following in the locker ex.) Watch / wallet / purse / credit cards / cash cards / commuter passes (tickets) / keys / mobile phone / belt / hairpins / dentures / hearing aid / glasses / pocket warmer(pocket stove) / magnetic poultices / bras.

(2) MRI scanning takes 15 to 30 minutes, Use the lavatory, if necessary, before the examination.

(3) Should you have any questions, please ask the staff.

Tokyo Neuro Center

Questionnaire

Date:	
Name:	

Mark as ☑ the symptoms or conditions that match yours within each question.
Should you mark any symptom/condition within a question, answer yes to the question.

1	☐ Headache ☐ Heaviness in head	Yes	No
2	☐ Neck pain ☐ Stiff neck	Yes	No
3	☐ Stiff shoulders ☐ Heaviness in shoulders	Yes	No
4	☐ Tendency to catch a cold easily ☐ Often have a slight cold	Yes	No
5	☐ Dizziness ☐ Feeling that the ceiling/things around were spinning	Yes	No
6	☐ Floating feeling ☐ Unsteadiness ☐ Unstable feeling without reason	Yes	No
7	☐ Nausea ☐ Poor appetite ☐ Stomachache/upset stomach ☐ Difficulty swallowing	Yes	No
8	☐ Difficulty falling asleep ☐ Waking up frequently during the night	Yes	No
9	☐ Unstable blood pressure ☐ Blood pressure reaches around 200	Yes	No
10	☐ Difficulty staying in a warm place for long ☐ Difficulty staying in a cold place for long	Yes	No
11	☐ Easily get sweaty ☐ Rarely perspire	Yes	No
12	☐ Heart suddenly starts pounding, thought at rest ☐ Pulse suddenly starts racing	Yes	No
13	☐ Difficulty seeing things ☐ Blurred vision	Yes	No
14	☐ Eyes get tired easily ☐ Pain in eyes	Yes	No
15	☐ Light sensitivity ☐ Difficulty keeping eyes open	Yes	No
16	☐ Dry eyes ☐ Excessively watery eyes	Yes	No
17	☐ Dry mouth/difficulty producing saliva ☐ Producing too much saliva	Yes	No
18	☐ Slight fever ☐ Slight fever without known cause	Yes	No
19	☐ Prone to diarrhea ☐ Constipation ☐ Abdominal/bowel symptoms (e.g. stomachache)	Yes	No
20	☐ Want to lie down any time ☐ Often lying down during daytime	Yes	No
21	☐ Prone to fatigue (general malaise) ☐ Whole body feels listless	Yes	No
22	☐ Difficulty getting motivated ☐ Lack of willingness/desire	Yes	No
23	☐ Symptoms get more pronounced before bad weather ☐ Can predict weather	Yes	No
24	☐ Get depressed ☐ Likely to feel gloomy	Yes	No
25	☐ Difficulty concentrating on one thing	Yes	No
26	☐ Feel anxious without reason ☐ Always feel anxious	Yes	No
27	☐ Irritable ☐ Nervous	Yes	No
28	☐ Difficulty staying focused ☐ Difficulty keeping up with work/study	Yes	No
29	☐ Hot flash ☐ Cold sensation in hands/feet ☐ Numbness	Yes	No
30	☐ Chest pain ☐ Chest pressure ☐ Numbness in chest	Yes	No
	TOTAL		

Questionnaire II

NAME:	DATE

Mark as ☑ the symptoms or conditions that match yours within each question.
Should you mark any symptom/condition within a question, Check "Yes" to the question.

1	☐ Difficulty swallowing	Yes	No
2	☐ Discomfort in throat or feeling as if something was stuck in throat	Yes	No
3	☐ Discomfort in stomach or bloating	Yes	No
4	☐ Stomach ache or pain in the pit of stomach	Yes	No
5	☐ Nausea	Yes	No
6	☐ Poor appetite ☐ Loss of weight	Yes	No
7	☐ Diarrhea/ loose bowel movements	Yes	No
8	☐ Constipation for days	Yes	No
9	☐ Alternating between diarrhea and constipation	Yes	No
10	☐ Irregular bowel movements or incomplete stool evacuation	Yes	No
	TOTAL		

Mark "Yes" if a question matches your symptom; otherwise, mark "No"

1	I feel depressed. I feel gloomy	Yes	No
2	I lack willingness/desire	Yes	No
3	I am anxious without any reason	Yes	No
4	I am enormously distressed by my poor health condition. Should this condition continue for the rest of my life, I would rather die.	Yes	No
5	I feel irritable. I feel nervous.	Yes	No
6	I am less able to make a judgment/decision	Yes	No
7	I am less able to concentrate.	Yes	No
8	I have difficulty staying focused/keeping up with work	Yes	No
9	I feel sad without any reason; I always feel so sad that my eyes fill with tears	Yes	No
10	Nothing seems to matter.	Yes	No
11	Nothing can interest me.	Yes	No
12	I do not find any fun in anything that should be fun. I can't find joy.	Yes	No
13	Everything looks meaningless, regardless of its importance or preciousness	Yes	No
14	I feel responsible for the things I have no connection to; I always blame myself.	Yes	No
15	I think the world doesn't need me; I think I should not exist in this world.	Yes	No
16	I have less appetite.	Yes	No
17	I have difficulty falling asleep.	Yes	No
18	I am prone to fatigue. I feel tired.	Yes	No
	TOTAL	Yes	No