NEW PATIENT INFORMATION SHEET

Date: _____

Name: _____

Last Fist Middle Initial

Address: _____

Postal Code Prefecture City Number

Phone Number: _____

Date of Birth: _____

Please Answer the Following Questions.

(History of Present Illness)

1. What is the main problem(s) that you would like to talk about?
   Please describe. _____
2. How long have you been having the problem(s)?
   Please describe. _____
3. Have you been seeing any psychiatrist/psychologist before this visit?
   Please check: ☐Yes / ☐No

(Social History)

4. Where were you born and raised? _____
5. Do you have any siblings? _____
6. Who are your caregivers?
   If the caregivers are not your parents, please specify. _____
7. Please fill in your educational background.
    1. Years of schooling _____ years (e.g., graduate high school = 12 years).
    2. How were your grades?
        1. Primary school ☐Excellent / ☐Average / ☐Poor
        2. Middle school ☐Excellent / ☐Average / ☐Poor
        3. High school ☐Excellent / ☐Average / ☐Poor
        4. University, College, Graduate School, etc.,
           ☐Excellent / ☐Average / ☐Poor

Please go on to the next page.

8. What is your occupation?
    1. Previous Position _____ Date Started _____ Date Stopped _____

    2. Current Position _____ Date Started _____ Date Stopped _____
9. If you have traumatic events in life, please describe.

    _____

(Other History)

10. Do you have family members diagnosed with mental disorders?
    If yes, please explain. _____
11. Do you have any previous medical history (including injury)?
    If yes, please describe. _____
12. Are you currently under the care of a physician and taking any medication?
    If yes, please explain. _____

    _____

    _____
13. Are you allergic to any medication?
    If yes, please list. _____
14. Do you use the following? Please check and if yes, specify the frequency (times per day, week, month).

☐Tobacco	Frequency _____	per ☐day / ☐week / ☐month
☐Caffeine	Frequency _____	per ☐day / ☐week / ☐month
☐Alcohol	Frequency _____	per ☐day / ☐week / ☐month
☐Marijuana	Frequency _____	per ☐day / ☐week / ☐month
☐Heroin	Frequency _____	per ☐day / ☐week / ☐month
☐Cocaine	Frequency _____	per ☐day / ☐week / ☐month
☐Hallucinogens	Frequency _____	per ☐day / ☐week / ☐month
☐Other	Frequency _____	per ☐day / ☐week / ☐month

Thank you for your cooperation.

Your personal / medical information and anything you discuss with your doctor is kept confidential.