First visit form

Today's date : Year Month Date

Name:

Date of Birth: Year Month Date

Nationality:

Address :

Home Phone:

Cell phone:

Emergency Contact: Name

Relationship

Phone number

How did you know this hospital ?

1. Homepage 2. Family / Friend 3. Information from Medical professionals
4. Brochure 5. Newspaper, Magazine 6. Advertisment
7. Other: Describe

Japanese language ability:

Speaking	(Fluentl	Daily conversation	a little	very limited)
Reading	(Well	Can read Okay	Only Hiragana	Very limited)
Writing	(Well Easily	Can Write Okay	Only Hiragana	Very limited)

How long have you been in Japan?

Type of health insurance: 1. National Health Insurance 2. Employment based health insurance
3. Other: Describe

Initial Intake Form

Please answer to the following questions to the best of your knowledge.

The information obtained from this intake form will help you and your doctor/counselor further discuss your concerns.

Name:_____ Age:_____ Gender: F · M (Please circle one) Nationality: _____

1. What are your current concerns? Please circle all that apply.

• Headache	• Difficulty sleeping	• Feeling blue	• Feeling as if surrounding environment and/or people have changed
• Nauseous	• Irritable	• Feeling sad	
• Dizziness	• Anxious	• Lacking motivation	• Feeling as if people give me strange/peculiar look
• Ear Pressure (ringing in the ears)	• Unable to think through	• Talking less	• Feeling as if people talk behind my back
Seizure	• Heart racing	• Feeling suicidal	• Able to see and hear things that others can't
• Fainting	• Shoulder pain	• Lacking appetite	
• Hand shaking	• Worrying about	• Lacking sexual desire	•Avoiding people and preferring Isolation (i.e., staying in a room)
• Slurred speech	• Checking things repeatedly in order to reduce anxiety	• Getting tired easily	•Talking incoherently •Behaving irrationally
• Forgetful	• Not feeling active or lively	• Becoming hyperactive	• Unable to stop drinking

Please share things you would like your counselor to know here.

2. When did the symptoms you listed above start?

Month/Year : _____ Age of onset: _____

3. Can you think of any factors that are associated with the development of your symptoms?

(Please circle one) Yes No

If Yes, please describe:

4.History of mental health related services.

A. Have you received counseling service in the past? (Please circle one) Yes No

If Yes, please specify the duration of each service. (Please circle one) Inpatient or Outpatient

1) From _____ / _____ to _____ / _____

(Month) (Year) (Month) (Year)

2) From _____ / _____ to _____ / _____

3) From _____ / _____ to _____ / _____

Inpatient or Outpatient

B. Have you received psychiatric service in the past? Yes: ____ No: ____

If Yes, please specify a duration of each service. Inpatient or Outpatient

1) From _____ / _____ to _____ _____
(Month) (Year) (Month) (Year)

2) From _____ / _____ to / _____ / _____

3) From _____ / _____ to / _____ / _____

Please list the medications you have taken in the past (if any):

Name of Medication and dosage: _____ When: _____

C. Have you been hospitalized due to mental illness in the past? Yes: No:

If Yes, please specify Month, Year and the place of your hospitalization.

1. Month: _____ Year: _____ Place: _____

2. Month: _____ Year: _____ Place : _____

5. Please indicate any illness or injury you experienced in the past.

_____ _____ / _____

(Name of Illness/Injury) (Month) (Year)

_____ _____ / _____

6. Please circle the ones that apply to you.

• Introvert	• Extrovert	Serious	• Punctual
• Perfectionist	• Nerrous		
• Passionate / devoted	• Cheerful	• Quiet	Selfish
• Short tempered	• Suspicious	• Positive/Active	• Passive

Please indicate other personal characteristics that apply to you.

7. Education & Life History

A. Highest education received (Please circle one):

• Elementary school	• Middle school	• High school	• Vocational school
• Two-Year college	• Four-Year college	• Graduate school (master's degree and/or higher)	

B.Place of birth: _____

C.Parents Occupations: Father: _____ Mother: _____

D. Your Occupation: _____ from _____ / _____ to _____ / _____
(month) (year) (month) (year)

E. Marital Status:

Single, Married: _____ / _____ (Month/Year), Living Together Not Married, Divorced: / _____ (month)(year)

8. Genogram (i.e., circle depicts female, square depicts male, X depicts death) ex.

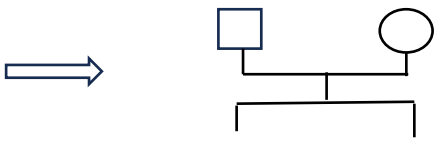
Father （ ） years old Mother ( ) years old

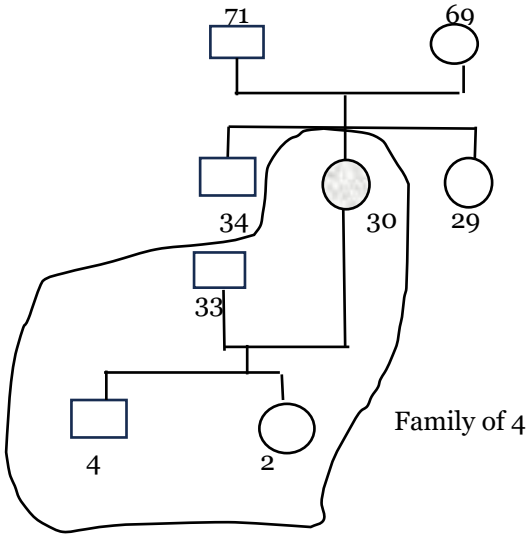
Parents

Brothers & Sisters

Husband & Wife

Children





Family of 4

9. (Please circle one)

A. Alcohol: Yes No If yes, how often: (_____)

B. Smoking: Yes No If yes, how often: (_____)

C. Medication Yes No If yes, please specify your medication and dosage

Yes (_____)

10. Do you have allergies? (Please circle one) Yes No

•If yes, please describe: (_____)