

**Confidential Client History**

**こちらのシートをご記入後、ドクターの最初のコンサルテーションの際にお持ちください。シートは単語で構いませんので、なるべく英語で書いていただき、わからないところは**

**日本語でご記載ください。**

Name –名前\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address – 住所 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Country –国籍\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone –電話番号\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email –メールアドレス\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth –生年月日\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age – 年齢\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender –性別\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital status – 結婚 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_No. of children –子供\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation–職業\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Review of Concerns今身体で気になっていること**

List your chief complaint and any other significant symptoms that you are concerned about. If you have been diagnosed with any disease or condition, list them as well.

あなたが直したい症状と懸念している症状を記入してください。既に病気と診断されている場合は、それらも記載してください。

Main complaint - 主な症状\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Other complaints –その他の症状\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_

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Diagnosed conditions– 診断を受けた症状 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**General Health and Lifestyle Patterns**

普段の健康状態とライフスタイルのパターン

1. Do you exercise regularly? Yes / No

定期的な運動はしていますか？

Length of time時間: \_\_\_\_\_\_\_\_\_\_\_ Times per week週何回: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. How much of the following do you drink?

次の飲み物のうち、当てはまる内容を教えて下さい。

(Note: 1 cup = 8 ounces １杯=約237ml)

* Water 水

No. of cups per day 1日あたり何杯: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Non – caffeine beverages ノンカフェイン飲料:

No. of cups per day 1日あたり何杯: \_\_\_\_\_\_\_\_\_

Types種類 : Herbal tea ハーブティー/ Milk tea ミルクティー/ juice ジュ

ース/ otherその他

* Caffeinated beverages : カフェイン飲料

No. of cups per day 1日あたり何杯:\_\_\_\_\_\_\_\_\_

types種類 : coffeeコーヒー / teaお茶 / sodaソーダ

* Alcohol :アルコール

No. of cups per day / week / month (please circle)

　　　どれぐらいの頻度でどれぐらいの量を飲みますか？

　　　\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you currently smoke ?タバコは吸いますか？ Yes / No

If yes how many cigarettes per day タバコを吸う人は、1日何本吸いますか？

: \_\_\_\_\_\_\_\_\_ How long do you smoke 何年ぐらい吸ってますか？: \_\_\_\_\_\_\_

If no , have you ever smoked ? 吸わない人は、今まで吸った事はありますか？Yes / No

If yes when did you quit ? 今まで吸った事がある人は、いつやめましたか？\_\_\_\_\_\_\_\_\_\_\_

1. Any current or past use of addictive substances ?

現在またが過去に、中毒性のあるものを使用した事はありますか？

Yes / No

When did you quit if you have used to before ?

使用した事がある人は、いつですか？ \_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you experience allergic reaction to any substances (ex : food , drugs , environmental conditions ect. ) please explain

アレルギーはありますか？(食べ物、お薬、環境条件、その他)

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1. What type of work you do? どのようなお仕事をされてますか？

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**Dietary Patterns食事のパターン**

What kind of taste do you prefer ? please circle one of the followingsどのような味が好みですか？次のいずれかにチェックしてください。

sweet 甘味/ sour 酸味/ salty 塩味/ pungent 辛味/ bitter 苦味/ astringent渋味

Any current or past chronic eating disorders or other food related issues ?

現在、または過去において、慢性摂食障害または、その他の食べ物に関連する症状が出たことはありますか？

Yes / No

If yes please explain はいの場合は、内容を記入してください。:

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Please indicate your primary food choices , beverages and meal times

あなたの食事の時間、食べている物、飲み物を記入してください。

Food choices and beverages 　　　　　　　　　 Meal time

Breakfast :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Lunch :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Dinner :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Snacks :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

**Current Medications , Herbs or Supplements**

**医薬品、またはサプリメントについて**

What medications are you currently taking or have taken recently , including birth control and hormone replacement therapy ?

現在、どんな薬を服用してますか？避妊ピルやホルモン剤も含みます。

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Are you currently taking any herbal remedies or supplements ? If yes please list

現在、ハーブやサプリメントを服用してますか？はいの場合は、詳細をご記載ください。

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**For women only女性の方のみ**

**Menstrual history生理について**

When did you have your last period / menstration ?

最後の生理はいつですか？

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Period cycle (mention the days 28 days , 30 days , if other please describe )

生理周期(28日や30日、その他の場合も記入してください。)

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How long is your bleeding days for??

生理期間中、出血の期間は通常どのくらいですか？

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your period is / was , heavy / light ?

生理中の症状は重いですか？軽いですか？

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any other difficulties that you feel while menstruation? Please explain

生理中に感じる他の問題があれば記入してください。

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Are you Menopaused ? 閉経してますか？

Yes / No

Do you have any pre / post menopausal symptoms? Please describe

その前後で更年期障害のような症状はありましたか？

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there any possibility that you are pregnant?

妊娠している可能性はありますか？

Yes / no

Have you been under the care of a licensed health care practitioner in the past year ?

昨年医者に掛かりましたか？

Yes / No

If yes for what reasons はいの場合の理由:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Date of last physical exam最後の検査の日付 : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature署名 : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date日付 : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_