For Patients Visiting the Department of Psychosomatic Medicine

Name:_____ Age:_____y.o.

Sex: Male ・ Female Marital status: Married / Single/ Divorced/ Bereavement

Occupation:_____ Type of work:_____

Phone Number (Please provide a phone number where we can reach you if necessary) Tel._____

1. Specify the issues you currently face. *Place them in order, from the biggest issue first.

①_____
②_____
③_____
④_____
⑤_____
Others_____
_____

2. Provide background information on the symptoms of the above problems.
(Give details such as when the symptoms started and under what circumstances, any changes in the symptoms, history and results of treatment.)

_____
_____
_____
_____
_____
_____

◆ **How did you hear about our Department of Psychosomatic Internal Medicine?**

_____

3. Have you had any previous serious illness surgery or have you been hospitalized before?

Age	Illness	Hospital where you have been treated	Details of treatment	Results of treatment

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4. Do you have any allergies? Yes ・ No

Medication _____

Food _____

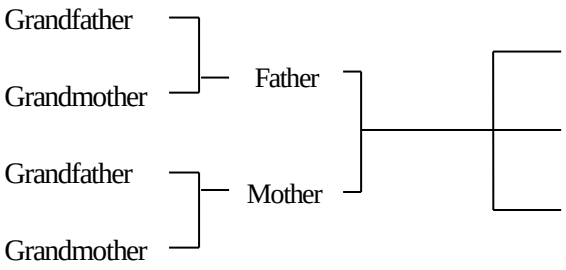
5. List any medications you are currently taking.

_____

_____

_____

6. Complete the following about the structure and medical history of your family.
***Include yourself and any brothers or sisters.**



Relationship with anyone who has the following illnesses

High blood pressure	( )
Stroke	( )
Heart disease	( )
Cancer	( )
Diabetes	( )
Asthma	( )

*** Who was primarily responsible for your upbringing?** (Father / Mother / Other)

7. Last school or employment

_____

_____ (years of continuous service)

8. Daily routine

Time when you get up: _____ Time when you go to bed: _____

Time when you start work: _____ Time when you finish work: _____

Average working hours: _____ Meals: ____ times /day Appetite: good, poor

Smoking habit: _____cigarettes / day, never

Daily alcohol intake: Japanese sake, beer, wine, other_____ml / day, at times, never

Sport or regular exercise: _____ Hobbies: _____

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9. During the past 4weeks, how much have you been bothered by any of the following problems ?

		Not bothered at all	Bothered a little	Bothered a lot
1)	Stomach pain	☐	☐	☐
2)	Back pain	☐	☐	☐
3)	Pain in your arms, legs, or joints (knees, hips, etc.)	☐	☐	☐
4)	Menstrual cramps or other problems with your periods (women only)	☐	☐	☐
5)	Headaches	☐	☐	☐
6)	Chest pain	☐	☐	☐
7)	Dizziness	☐	☐	☐
8)	Fainting spells	☐	☐	☐
9)	Feeling your heart pound or race	☐	☐	☐
10)	Shortness of breath Palpitations or quick pulse	☐	☐	☐
11)	Pain or problems during sexual intercourse	☐	☐	☐
12)	Constipation, loose bowels, or diarrhea	☐	☐	☐
13)	Nausea, gas, or indigestion	☐	☐	☐
14)	Feeling tired or having low energy	☐	☐	☐
15)	Trouble sleeping	☐	☐	☐

≪PHQ-15 (Patient Health Questionnaire-15) by Kroenke K, Spitzer RL et al 2002≫

10. What is your impression of your current situation? Please include any ideas you might have about possible factors that caused or triggered your symptoms.
(including stress arising from your living environment or personal relationships at home, school or work).

11. How would you like things to change or to change things in the future?

12. At St. Luke's International Hospital, patients are treated with blood transfusion when deemed medically necessary. Do you agree to undergo blood transfusion in the event it becomes medically necessary? Yes ・ No

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Social Adaptation Self-evaluation Scale:

Do you have an occupation? Yes No

1) (If yes) How interested are you in your occupation?

3: very 2: moderately 1: a little 0: not at all

2) (If no) How interested are you in your home-related activities?

3: very 2: moderately 1: a little 0: not at all

3) Do you pursue this occupation, these activities with : ?

3: a lot of enjoyment 2: some enjoyment 1: only a little enjoyment 0: no enjoyment at all

4) Are you interested in hobbies/ leisure?

3: very 2: moderately 1: a little 0: not at all

5) Is the quality of your spare time: ?

3: very good 2: good 1: fair 0: unsatisfactory

6) How frequently do you seek contacts with your family members (spouse, children, parents, etc.) ?

3: very frequently 2: frequently 1: rarely 0: never

7) Is the state of relations in your family: ?

3: very good 2: good 1: fair 0: unsatisfactory

8) Outside of your family, do you have relationships with: ?

3: many people 2: some people 1: only a few people 0: nobody

9) Do you try to form relationships with others: ?

3: very actively 2: actively 1: moderately actively 0: in no active way

10) How – in general – do you rate your relationships with other people ?

3: very good 2: good 1: fair 0: unsatisfactory

11) What value to you attach to your relationships with others?

3: great value 2: some value 1: only a little value 0: no value at all

12) How often do people in your social circle seek contact with you?

3: very often 2: often 1: rarely 0: never

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13) Do you observe the social rules, good manner, politeness, etc.?

3: always 2: most of the time 1: rarely 0: never

14) To what extent are you involved in community life (such as club, church, etc.) ?

3: fully 2: moderately 1: slightly 0: not at all

15) Do you like searching for information about things, situations and people to improve your understanding of them?

3: very much 2: moderately 1: not much 0: not at all

16) Are you interested in scientific, technical or cultural information?

3: very 2: moderately 1: only slightly 0: not at all

17) How often do you find it difficult to express your opinions to people?

3: always 2: often 1: sometimes 0: never

18) How often do you feel rejected excluded from your circle?

3: always 2: often 1: sometimes 0: never

19) How important do you consider your physical appearance?

3: very 2: moderately 1: not very much 0: not at all

20) To what extent do you have difficulties in managing your resources and income?

3: always 2: often 1: sometimes 0: never

21) Do you feel able to organize your environment according to your wishes and needs?

3: very much so 2: moderately 1: not very 0: not at all

≪SASS (Social Adaptation Self-evaluation Scale) by Bocs M et al. 1997≫

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