Mejiro Sola Clinic Intake Form

Today's Date: _____ (YYYY/MM/DD)

Please fill out the form below. All the information you provide will be kept confidential and not be released to a third party without your permission.

Your Name			
Date of Birth		**Age**	
Address			
Phone Number	**Email**		
Gender	☐ male ☐ female ☐ other		
Nationality		**Ethnicity**	
Marital Status	☐never married ☐married ☐partnered ☐separated ☐divorced ☐widowed		
Number of Children		**Year of Arrival in Japan**	
Highest Education	☐middle school ☐high school ☐college ☐graduate school		
Referred by	☐medical professionals ☐friends/family ☐homepage ☐other ( )		
Insurance Type	☐national ☐employment-base ☐other ( )		
If you have these certificates, please check	☐Jiritsushien (Medical Expense Subsidy to Support the Independence of People with Mental Disabilities) ☐disability pension ☐Seishin Shogaisha Hoken fukushi Techo (Certificate of the Mentally Disabled)		
Immigration Status	☐spouse visa ☐student visa ☐employment visa ☐citizenship ☐tourist ☐resident (long-term/ permanent) ☐refugee-claimant (special stay/ no visa/ provisional release) ☐other ( )		
Emergency Contact in Japan	**Relationship** ☐ family (spouse / sibling / other_____) **※Friends cannot be used as emergency contacts** ☐ company ☐ school **Name** **※If there is no emergency contact within the country, the embassy or consulate may be used as the contact.**		
	Phone Number		

Japanese Fluency:

Speaking	☐ Fluent	☐ Conversational	☐ A little	☐ Very little
Reading	☐ Well	☐ Okay	☐ Hiragana only	☐ Poor
Writing	☐ Well	☐ Okay	☐ Hiragana only	☐ Poor

Please tell us about your information.

Height: cm	Weight: kg
Alcohol: ☐No ☐Sometime ☐Often ☐Everyday	
Smoke: ☐No ☐Yes → /per day	
Drug abuse: ☐No ☐Yes (Past: / Currently:)	
Are you currently pregnant?: ☐No ☐Yes ・Breast feeding ☐No ☐Yes	
Allergy: ☐None If any, please check below: ☐Medicine or food (detail:) ☐Hay fever ☐Atopic dermatitis ☐Asthma ☐Other ( )	

Medical History

Glaucoma ☐No ☐Yes	Diabetes: ☐None ☐Yes
Blood Pressure or/and Heart Disease ☐None ☐Yes (detail:)	
Others, if any? ①Name of illness: (Age) ②Name of illness: (Age) ③Name of illness: (Age)	

Mental condition

Are you currently receiving mental health treatment elsewhere? ☐yes ☐no **If yes, where?**
Are you currently taking prescribed psychiatric medication? **If so, please list:**
Please write briefly your reasons for today's visit.