Suto Healing Center

First Name:________________ Last Name:________________

Home Phone:________________

Mobile Phone:________________

E-mail:________________

Male☐ Female☐
Date of Birth:________________
Married☐Single☐
Number of Children:________

Your Nationality:________________ Occupation:________________

Post Number:________________

Address:________________

Please indicate how you heard about our clinic and tell us the name of your source.

____

<Pregnancy>Your estimated delivery date:________________
Place:________________

< ABOUT YOUR SYMPTOM NOW >

What is your symptom?________________
When did it start?________________
What do you think is the cause?________________
Did you consult a doctor or other clinic before?
☐No / ☐Yes ①Department:________________
②Diagnosis:________________
③Details of treatment:________________

Medicine/Herbal medicine
☐None / ☐Yes(Name/Effect):________________

Physical examination
☐Did not take / ☐Within normal range / ☐ Abnormal:________________

< YOUR HISTORY >

Disease/Problems
☐Never / ☐I had(When/Diagnosis):________________

Accident / Injury
☐Never / ☐I had(When):________________

Surgery
☐Never / ☐I had(When/Hangover):________________

I understand that I am financially responsible for the services that recieve at SHC. I will satisfy my obligation in cash. Also, I here-by authorize the physician to treat me (or my dependent / minor child).

Patient Signature:________________ Date:________
(or Patient' s Parent / Guardian, if Minor)

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CONFIDENTIAL HEALTH HISTORY

In the space in front of each item, please draw "○" if you HAVE the problem now, or draw "△" if you have HAD the problem.

GENERAL

______Fever
______Chills
______Night Sweats
______Loss of Sleep
______Fatigue
______Nerousness
______Weight Loss or Gain
______Allergies
(Name:)
______Bleeding Problem
______Anemia
______Diabetes
______Cancer (Name:)
______Thyroid Disease
______Goiter
______Alcoholism
______Drug Abuse

EYE EAR NOSE THROAT

______Poor Vision
______Pain in Eye(s)(Right/Left/Both)
______Deafness/Difficulty Hearing (Right/Left/Both)
______Nosebleeds
______Nose Problems
______Sinus Problems
______Dental Problems
______Hoarseness
______Tonsillectomy

GASTROINTESTINAL

______Poor Appetite
______Poor Digestion
______Difficulty Swallowing
______Belching or Gas
______Frequent Nausea
______Vomiting
______Vomiting Blood
______Pain over Abdomen
______Ulcer
______Black or Bloody Stools
______Liver Problems
______Gall Bladder Problems
______Jaundice
______Hernia
______Diarrhea
______Constipation
______Hemorrhoid
______Appendicitis

NEUROLOGIC

______Weakness
______Twitching
______Tremors
______Headache
______Fainting
______Dizziness
______Convulsing
______Epilepsy
______Numbness/Tingling
______Arm/Leg Pain
______Mental Disorder

RESPIRATORY

______Difficulty Breathing
______Chronic Cough
______Spitting Phlegm
______Spitting Blood
______Wheezing/Asthma
______Pneumonia
______Tuberculosis

CARDIOVASCULAR

______Irregular Heartbeat
______High Blood Pressure
______Pain over Heart
______Previous Heart Trouble
______Ankle Swelling
______Varicose Veins
______Rheumatic Fever
______Stroke

GENITOURINARY

______Frequent Urination
______Painful Urination
______Blood in Urine
______Kidney Disease
______Urinary Infection
______Inability to Control Urination
______Difficulty Starting Urine Flow
______Get up____times per Night to Urinate
______Venereal Infection
______Sexual Difficulties

SKIN

______Itching
______Bruising Easily
______Change in Mole(s)
______Skin Cancer

MUSCULOSKELETAL

______Neck Stiffness/Pain
______Pain Between Shoulders
______Low Back Pain
______Swollen Joints
______Painful Joints
______Muscle Aches/Soreness
______Spinal Curvature
______Arthritis

MEN ONLY

______Testicular Swelling/Pain
______Prostate Problems

WOMEN ONLY

______Painful Periods
______Excessive Flow
______Irregular Cycles
______Vaginal Burning/Itching
______Hot Flashes
Date Last Period Began
____
Date of Last PAP Test
____
____Breast Lump or Pain

HABITS

______Smoking
_____Packs/day
______Drinking
______Recreational Drug Use

EXERCISE

______None
______1-2 times/week
______3-5 times/week
______6-7 times/week

FAMILY HISTORY

Include, information on brothers, sisters, parents and grandparents. DO NOT INCLUDE YOURSELF.

______Diabetes ( )
______Thyroid Disease/Goiter( )
______Tuberculosis ( )
______Kidney Disease ( )
______High Blood Pressure( )
______Heart Disease ( )
______Muscle, Bone or Nerve( )
______Cancer( )

①Height cm ②Weight kg ③Blood Pressure / mm/Hg ④ Left-hander・Right-hander

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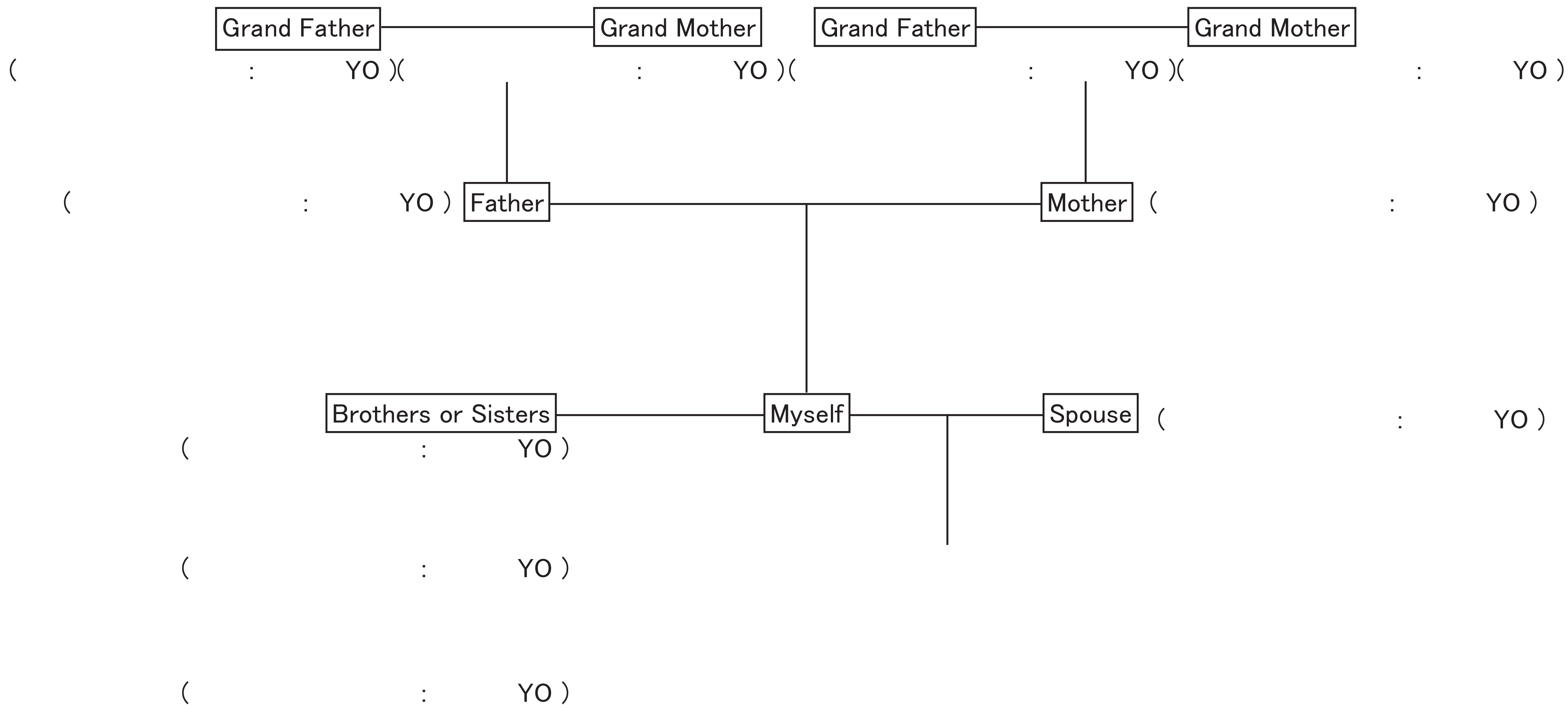
Family tree

Please write first name, last name and age into ( ). Please explain about his or her personality and impressive memories you have.

Example : 1.He loved me until I was 5 years old. (Tom Suto 75YO) Father —— Mother (Ann Suto 65YO) 1. Bright, caretaker.
2.He quit his job when he was 38 years old. 2. Past away 1995.
His personality changed. He became more regid.



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Suto Healing Center

Please type or send us Email (welcome@sutohealingcenter.jp) with the following required information.

1. Please list any traumatic or life threatening events in your life.

2. What do you hope for and what are your expectations from the energy work?

Thank you very much for your cooperation.

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