Suto Healing Center

First Name:_____ Last Name:_____

Male☐ Female☐

Home Phone:_____

Date of Birth:_____

(Day/Month/Year)

Mobile Phone:_____

Married☐Single☐

E-mail:_____

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/Aftereffect):_____

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)

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

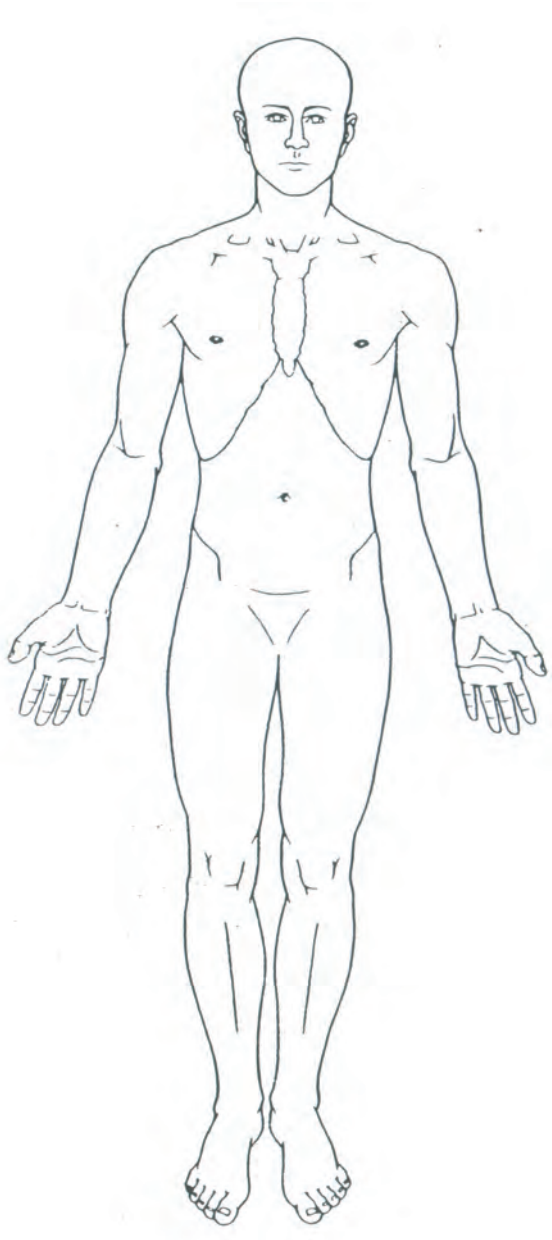
Include, information on brothers, sisters, parents and grandparents.
DO NOT INCLUDE YOURSELF.

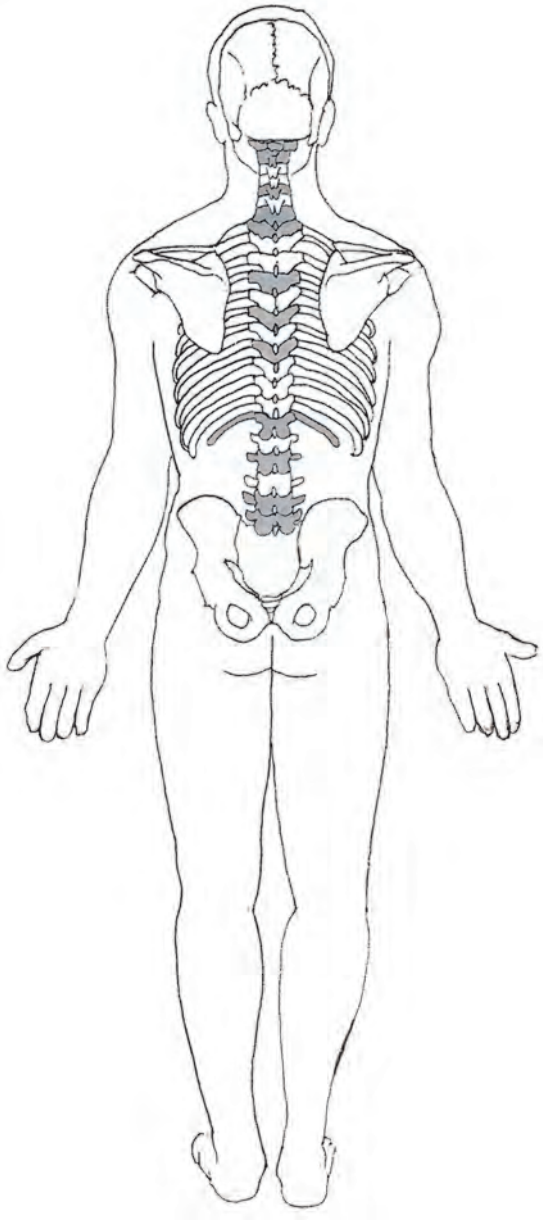
_____Diabetes ( )
_____Thyroid Disease/Goiter( )
_____Tuberculosis ( )
_____Kidney Disease ( )
_____High Blood Pressure( )
_____Heart Disease ( )
_____Muscle, Bone or Nerve( )
_____Cancer( )

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

Please draw your pain on the picture with the marks below.

—	:	No Sensation	●	:	Dull pain
○	:	Numbness	△	:	Tight Feeling
×	:	Burning Pain	／	:	Pin and Needle Pain
＊	:	Ache	□	:	Heavy Feeling





☸ YOUR GOAL ☸

When you recover from your symptom, what do you want to do first?