(ID. No.)

Interview Sheet

Dy /Mo /Yr

	A person who fills out this form is patient's (father, mother,)
	Name: (M･F) DOB: / / / ( )y.o. Birth Place: Nationality:
	ZIP code: Address: Phone: Mobile Phone: School/Kindergarten : ＊Please write down a name and a phone number of a person whom we could have contact with in case of emergency (Name: Mobile Phone:)

1. Describe main problems. When do they begin to start?

2. Have you ever consult a doctor with these problems? (Yes･No)
When? Where? Dr. in charge:
Outcome:

3. What your main expectations for us about the problems?
Diagnosis, Psychological testing, Prescription, Counseling, Others( )

4. Any abnormalities in perinatal period?
Yes・No( )

5. Any abnormalities at birth?
( ) weeks, Birth Weight ( ) g

6. Any abnormalities about developmental milestones?
Crawling ( ) m.o., Walking ( ) m.o., Say a few words ( )m.o.
If any, specify. ( )

7. Any problems during childhood?
Not looking into others' eyes, Speech, Play by oneself, Collecting specific things,
Absent minded, Not sitting still.
If any, specify. ( )

8. Any problems at school?
About friends: Yes・No ( )
About study: Yes・No ( )
If any, specify. ( )

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9. List your past illness.

( ) y.o.:

( ) y.o.:

10. Are you under medication?

Yes・No( )

11. Past history of allergy? (Yes・No)

Foods( ) Medicine( )

12. Specify your family member including past history.

13. Please describe anything you would like to let a doctor know before consultation.

14. How did you get the information of our office?

Friends ( ), Web (PC, Mobile), Others ( )

―Thank you very much in advance for your cooperation.―