Today's date / / Name: M / F Age:

Pain and Fatigue – Patient Health Questionnaire V16.4

Chiyoda International Clinic

(Information and statements made here are for treatment purposes and treated in compliance with the clinic's rules.)

Please write in pen.

- What is the reason for your visit? What symptoms or health problems do you have?

  _____

  _____

- What do you seek today? (Circle all that apply.)
  - Diagnosis and treatment
  - Consultation
  - Second opinion

- List all the hospitals you visited, doctors you saw, and diagnosis and treatment you received after developing your illness. What effects did the treatment have on you?

  e.g. 1) 22 years old with back pain. Diagnosed with Neck-Arm syndrome at Yamada orthopedic hospital (Suzuki MD). Nerve blocks. No effect.
  e.g. 2) 24 years old with widespread pain. Diagnosed with depression at Sato clinic (Sato MD). Anti-depressants. Suffered from a side effect (dizziness). Termination of drug therapy after 3 months.

- How did you get to know us? (Please circle all that apply.)
  - Internet, magazines (title:), books (title:), friends, patients, doctors, dentists, nurses, acupuncturists, psychotherapists, pharmacologists, others ( )

- What is your occupation? (Please be specific.)

  _____

- Please state your height in centimeters and weight in kilograms.
  Your height: _____ cm
  Your current weight: _____ kg
  Your weight at the age of 20: _____
  The lightest weight in your adulthood: _____ kg / age _____
  The heaviest weight in your adulthood: _____ kg / age _____

- Medications – Circle YES or NO.
  - Have you taken medications for high blood pressure? YES / NO
    If yes, what were you prescribed? At what age (and how long) did you take them?

    _____

  - Have you taken medications for low blood pressure? YES / NO
    If yes, what were you prescribed? At what age (and how long) did you take them?

    _____

  - Have you taken anti-depressants? YES / NO
    If yes, what were you prescribed? At what age (and how long) did you take them?

    _____

  - Have you taken antiepileptic drugs? YES / NO
    If yes, what were you prescribed? At what age (and how long) did you take them?

    _____

  - List the medications you are taking. Circle medications you wish to continue. Cross medications you wish to discontinue.

    _____

    _____

- List all the medications taken that were (a) effective, and (b) not effective.
  (a) _____
  (b) _____

- Treatment – Have you received the following treatment? Circle all that apply.
  - Nerve blocks
    If yes, were they effective? YES / NO
  - Acupuncture / Moxibustion / Massage
    If yes, were they effective? YES / NO
  - Counselling
    If yes, was it effective? YES / NO

- Circle all that you like. Cross what you dislike.
  - Music, Paintings, TV, Radio, Perfumes, Make-up, Chatting, Sports, Dancing, Travelling, Taking a bath, Spas
  - Other Likes: _____
  - Other Dislikes: _____

- When do you relax most?
  _____

- Activities and rest
  - Do you overdo things, rather than trying to pace yourself, when you feel well? YES / NO
  - How many hours do you lie in bed except for a night sleep? (hours)
  - Do you feel your pain and fatigue are getting worse? YES / NO
  - Do your symptoms continue for more than half a year? YES / NO
  - Do you tend to overwork because you can hardly refuse? YES / I don't know. / NO
  - Do you tend to avoid things that may cause trouble? YES / I don't know. / NO

- Your lifestyle
  Current eating habits
  - How does your diet taste? Strong / Mild / Light
  - Do you have food preferences? NO / A little / Many

- What is your favorite food? _____
- What is your least favorite food? _____
- Do you have a balanced diet? Always / Sometimes / Never
- Do you drink up soup when you eat noodles? Always / Sometimes / Never
- Do you like salty food? YES / NO
- Do you like sweet food? YES / NO
- Do you feel nauseous after eating sweet food? YES / NO
- Do you like fatty foods? YES / NO
- Do you experience heartburn? Always / Sometimes / Never
- Do you intentionally burn or char your fish and meat while cooking? YES / NO / I don't know.
- Do you eat enough vegetables? YES / NO
- Do you eat enough fish and meat? YES / NO
- Do you try to eat less bread and rice? YES / NO
- Do you put something like a candy in your mouth when you begin to feel hungry? YES / NO
- Do you swallow food without chewing properly? YES / NO
- Do you have 3 meals a day? Always / Sometimes / Never
- Do you have breakfast? Always / Sometimes / Never
- Do you have a tea break? Always / Sometimes / Never
- Do you have a late meal? Always / Sometimes / Never
- Do you eat between meals? Always / Sometimes / Never
- Do you gorge yourself? Always / Sometimes / Never
- Do you eat quickly? Always / Sometimes / Never
- How large is your mouthful of food is? Large / Medium / Small
- Do you eat alone? Always / Sometimes / Never
- Do you feel full after eating a small amount of food? Always / Sometimes / Never
- Do you feel drowsy after eating? Always / Sometimes / Never
- Do you feel lethargic after eating? Always / Sometimes / Never
- Do you suffer from the loss of appetite or excessive appetite? Always / Sometimes / Never
- Do you smoke?

  Yes, I always smoke. / Yes, I sometimes smoke. / NO / I used to smoke.

  How many cigarettes on average do you smoke per day? _____

  At what age did you start smoking? Age: _____

- Do you drink alcoholic beverages? YES / NO
  How often do you drink?
  Almost every day / More than 3 times a week / only occasionally
  At what age did you start drinking? Age: _____

Past eating habits

- Have you ever been anorexic? YES (age:) / NO
- Have you ever been bulimic? YES (age:) / NO
- Did you eat with your family? Always / Sometimes / Never
- Have you ever been on a diet? YES (age:) / NO
- What school clubs did you join?
  At junior high school: _____
  At senior high school: _____
- Did you skip breakfast? YES (age:) / NO
- Did you gorge yourself? YES (age:) / NO
- Did you eat quickly? YES (age:) / NO
- Did you feel full after eating a small amount of food?
  YES (age:) / NO
- Have you ever taken dancing and/or ballet lessons?
  YES (age:) / NO
- Have you ever experienced weight gain or weight loss by more than 5 % in one month? YES (age:) / NO

Hygiene

- How often do you take a bath? Everyday / ( ) times per week
- Do you soak in the bath a) up to the shoulder, or b) from the waist down?
  Or do you only take a shower?
- How long do you soak in the bath?
  Less than 5 minutes / Between 5 and 10 minutes / More than 10 minutes
- How hot is your bath? (℃)
- Do you use spa powder?
  YES (name(s) of the powder:) / NO
- Do you like spas? YES / NO / I don't know.

Sleep

- How many hours do you usually sleep?
  Less than 6 hours / Between 7 and 8 hours / More than 9 hours
- Do you have sleep disorders? YES / NO
  If yes, what are you suffering from? Circle all that apply:
  Having difficulty falling asleep / Having nightmares / Moaning because of nightmares / Being unable to sleep deeply / Being unable to maintain sleep through the night / Waking up too early in the morning / Having panic attacks during the night / Having night sweats / Having convulsions during the night
- Are you taking sleeping pills?
  YES (name(s) of the pills:) / NO
- How is your posture while sleeping? Good / Bad / I don't know.
- Do you snore while sleeping? YES / NO / I don't know.
- Do you clench your teeth while sleeping? YES / NO / I don't know.
- Do you sleep on your stomach? YES / NO / I don't know.
- Do you take a nap? Often / Sometimes / Never
- Do you have apnea? YES / NO / I don't know.
- What do you sleep on?
  Bed / Futon / Sofa / Others ( )
- Do you keep an air conditioner off during the night in summer and winter?
  Always / Sometimes / Never

Excretion

- Circle all that apply.
  Having regular bowel movement / Having diarrhea frequently /Experiencing constipation frequently / Having diarrhea and constipation happen one after another / Having excess intestinal gas / Having sticky stools / Experiencing bloating / Using laxatives List all the laxatives you use.: ; since when?:
- How often do you urinate in a day? (times)
  What is your urine volume?
  Excessive / Normal / Scanty / Unable to urinate / I don't know.
- Do you wake up during the night to urinate?
  Yes (How often?) / No

Exercises

- Do you exercise that makes you sweat? Always / Sometimes / Never
- What do you do? (Circle all that apply.)
  Jogging / Walking / Radio calisthenics / Yoga / Tai chi chuan / Swimming / Dancing / Volleyball / Others ( )
- Did you used to do physical activities? YES / NO
  What and how long did you do? _____
- Do you do morning workout, breathing exercises, or leg lift?
  Always / Sometimes / Never

- What symptoms did you have or do you have? Circle all the symptoms you are suffering from and cross what you experienced.
  - Having trouble waking up in the morning / Feeling unwell during the morning / Unsteadiness / Dizziness / Light-headedness when standing up / Fainting / Shakiness/ Paleness / Blurred vision / Sensitivity to light / Double vision / Fast heart rate / Slow heart rate / Arrhythmia / Atrial fibrillation / Chest pain (feeling squeezing in the chest) / Palpitation / Shortness of breath / Small heart / Hot flashes

  - Having difficulty breathing / Overbreathing / Bronchitis

  - Fatigue (chronic fatigue) / Yawning / Hyperhidrosis (excessive sweating) / Anhidrosis (absent sweating) / Night Sweats / Decreased stamina / Coldness / Hypothermia / Frostbite / Being unable to tolerate air conditioner / Being prone to hyperthermia (heat-related illness)

  - Catching a cold easily / Having an allergy / Sensitivities to medication / Dry skin

  - Feeling hungry after eating / Having increased appetite / Feeling nauseous after eating / Experiencing a loss of appetite / Nausea / Vomiting / Having unhealthy digestive system / Bad breath / Being unable to eat / Stomachache / Severe abdominal pain (intestinal obstruction)

  - Temporomandibular disorders / Headache / Widespread pain / Muscle pain / Numbness / Shoulder pain / Waist pain / Back pain

- Decreased cognitive function / Being unable to think clearly / Poor memory / Fatigue / Speech impediment / Feeling drowsy after eating / Having trouble understanding numbers and words correctly / Having trouble calculating correctly / Being unable to remember new things / Being argumentative / Being prone to an outburst of anger / Anxiety / Fear / Being hyperactive / Being nervous / Having a short temper / Behavior changes / Personality changes (e.g. becoming aggressive) / Confusion / Being stubborn

- Depression / Sensitivity to sensory stimulation (e.g. light, sound, smell or touch) / Despair / Feeling suicidal

- Experiencing confusion about one's location and identity / Suffering from sleeplessness during the night / Having panic attacks while sleeping / Having nightmares / Moaning in sleep / Being half asleep when waking up / Wandering around the streets / Shakiness / Convulsions / Abnormal behavior / Fainting (Loss of consciousness)

- Having experienced God / Having experienced ghosts / Having memories of the pre-birth experience / Frequently seeing ghosts and having inspirational experiences

[FOR WOMEN]

- Premenstrual syndrome / Menopause symptoms (Experiencing such symptoms as pain, mood changes, irritability, hot flashes) / Irregular periods

- Symptoms and seasons
  - Do you think your symptoms are seasonal?
    YES / NO / I don't know.
  - When do your symptoms get worse?
    Spring / Summer / Autumn / Winter / Seasonal transitions
  - When are you relatively in good health?
    Spring / Summer / Autumn / Winter / Seasonal transitions
  - Does bad weather makes your health condition worse?
    YES / NO / I don't know.

- Tell us about your family (father, mother, siblings, spouse, and/or children) and their health condition.
  e.g.) father (60 years old): diabetic for 5 years

- Did or does your family have any of the following symptoms or diseases? Check all that apply.
  ☐Hypertension ☐Hypotension ☐Thyroid disorder ☐Diabetes ☐Cancer
  ☐Myocardial infarction ☐Cerebral infarction ☐Depression ☐Bipolar disorder
  ☐Schizophrenia ☐Generalized anxiety disorder ☐Epilepsy ☐Atypical mental disorders ☐Mental disorders ☐Autonomic nervous system imbalances
  ☐General discomfort ☐Menopause symptoms ☐Psychosomatic diseases
  ☐Pancreatic diseases ☐Fibromyalgia ☐ME / CFS
  Who suffered or is suffering from it? _____
  At what age? _____

- Your medical history
  - What was your birth weight? _____ kg
  - Were you delivered by normal labor or abnormal labor (e.g. Caesarean operation)? _____

  - Check all that you have been diagnosed with. At what age did you get diagnosed?
    ☐Hypertension ☐Hypotension ☐Thyroid disorder ☐Diabetes ☐Cancer
    ☐Myocardial infarction ☐Cerebral infarction ☐Depression
    ☐Bipolar disorder ☐Schizophrenia ☐Generalized anxiety disorder
    ☐Epilepsy ☐Atypical mental disorders ☐Mental disorders
    ☐Autonomic nervous system imbalances ☐General discomfort
    ☐Menopause ☐Psychosomatic diseases ☐Pancreatic disease
    ☐Fibromyalgia ☐ME / CFS
    Age: _____

- What do you think you are suffering from? Check all that apply.
  ☐Fibromyalgia ☐ME / CF ☐Autonomic nervous system imbalances
  ☐Depression ☐Menopause symptoms ☐Hypotension ☐Hypoglycemia
  ☐Hypertension ☐Inflammation ☐Tumor ☐Schizophrenia ☐Epilepsy
  ☐Others ( )
  ☐I don't know. ☐I am seeking a diagnosis.

- What do you expect us to do for you? Feel free to make any comments.

- List diseases, accidents, injuries or operations that you have experienced in chronological order.
  e.g.) Pneumonia at the age of 15. Spent 5 days in Yamada Hospital (the department of respiratory medicine) and received antibiotics instillation. Treated as an outpatient for a month after discharge from the hospital.

- Describe your history (i.e. education, work and marriage) in chronological order. Circle all the events in your history that may be relevant to your illness.

- Below are important questions. State your opinions as specifically as possible.
  1. What really matters to you in your life?

  2. What brings joy and pleasure to you?

  3. What makes you desire good health?

  4. What would you like to do when you are restored to health?

Thank you for your time and cooperation.

Our principles: We support patients who desire to achieve autonomy through self-help, to take an active part in society, and to achieve healthy longevity. Let us help you to meet the challenges with confidence.