

# 【Health Handbook】

People with physical disabilities may face challenges with physical checkups or medical treatments, due to their deficits in communication skills.

In order to assist in their doctor's visit, treating clinicians and the family members are encouraged to fill in necessary information such as general health condition, consultation history and anything that requires special attention. Please make use of this handbook in your practice by referring to it as part of the patient's medical record. Any relevant information filled within this handbook will be important to ensure that care is coordinated among all health care professionals involved. Thank you in advance for your understanding and support.

Name \_\_\_\_\_ Gender ( male / female )

Nickname \_\_\_\_\_

Birthdate \_\_\_\_\_ y/ \_\_\_\_\_ m/ \_\_\_\_\_ d


## Contact Information

- Names of the parents or caregivers: (describe relationship)
- Address 〒 \_\_\_\_\_
- Telephone: ( \_\_\_\_\_ ) \_\_\_\_\_
- Cell Phone: ( \_\_\_\_\_ ) \_\_\_\_\_
- Other contacts:

## Level of function, Disability Category

- Physical disability certificate(level \_\_\_\_\_ ) ("Shintai Shogaisha Techo")  
Category: physical / auditory / vision / others
- Functional status  
rolling over( able / unable ) sitting( able / unable )  
standing( able / unable ) walking( able / unable )
- Intellectual disability( Yes • No )  
( intellectual capability of \_\_\_\_\_ years old )
- Disability Certificate("Ryoiku Techo") :  
not yet applied • not applicable  
mild( C ) • moderate( B ) • severe( A )

## A doctor's visit in relation to the disabilities

- Diagnosis: 
- Prescription information  
Acceptable formula: tablets/capsules/powder/liquid  
Medication (name, dose) : \_\_\_\_\_
- Hospital name:  
Phone( \_\_\_\_\_ ) \_\_\_\_\_
- Prescribing Physician:  
Pediatrics / Internal Medicine / other specialty ( \_\_\_\_\_ )
- Consultation frequency  
\_\_\_\_\_ times/ \_\_\_\_\_ weeks \_\_\_\_\_ times/ \_\_\_\_\_ months

- Details of recent medical condition that requires special attention:

Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Written by: \_\_\_\_\_



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It is our wish that both the patient and the medical institution will benefit from this handbook. Let us know if you have any questions or encounter any issues.

Issued by the City of Toyota



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## General Physical Condition

- Height \_\_\_\_\_ cm Weight \_\_\_\_\_ kg  
(date \_\_\_\_\_ y/ \_\_\_\_\_ m/ \_\_\_\_\_ d)
- Temperature \_\_\_\_\_ °C ( \_\_\_\_\_ F)
- Blood Type \_\_\_\_\_ Rh( \_\_\_\_\_ )
- O<sub>2</sub> saturation( \_\_\_\_\_ %)
- Blood Pressure( \_\_\_\_\_ / \_\_\_\_\_ ) (date \_\_\_\_\_ / \_\_\_\_\_ )
- Allergies Yes / No { allergen: \_\_\_\_\_ }
- Contraindication Yes / No { drug name: \_\_\_\_\_ }
- Epileptic Attack Yes / No  
(How often? \_\_\_\_\_ )

\* measures taken in case of the attack

## Health care needs, medical interventions

- Feeding (solids, tube feeding, both)
- Fluids ( food thickeners required / not required )
- Food preparation (regular foods/ chopped / ground / minced / puréed)
- Tube feeding (nasogastric / gastrostomy / enterostomy)  
Details:(Tube size \_\_\_\_\_ , brand name \_\_\_\_\_ )
- Aspiration (not required / oro-nasal / tracheal )
- Respiration management (not required / nasal airway / O<sub>2</sub> treatment / ventilator )  
Details:( \_\_\_\_\_ )
- Urinary catheterization (not required / required )  
Tube size ( \_\_\_\_\_ )Fr
- Inhalation (not required / required )  
Details:( \_\_\_\_\_ )
- Orthotic device  
electric wheel chair / wheel chair / walker / cane / orthopedic sitting device / upper limb orthosis / lower limb orthosis / others ( \_\_\_\_\_ )
- Other medical needs:



## Mobility conditions

- \* Comfortable posture:
- \* Joint contraction (part of the body: \_\_\_\_\_ )
- \* Restriction of movement (joint: \_\_\_\_\_ )

## Communication skills

- \* Comprehension  
spoken language (sentences • words) • letters(alphabet) • pictures / photos • showing actual objects • none of the above
- \* Expression  
spoken language (sentences • words) • sign language • writing • pointing • vocalization • none of the above ( \_\_\_\_\_ )

## Additional information

(Likes and dislikes, useful items or means to relieve anxiety, etc):

Family Doctor



● Clinic or Hospital:

Phone (        )        -

● Dentist:

Phone (        )        -

Familiar Prescription

(e.g. antibiotic, pain killer, antidiarrhea)

Horizontal lines for writing familiar prescription details.

Additional Information

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Date     /     /

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Additional Information

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Date     /     /

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Additional Information

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Medical history

● Diagnosis:

Doctor/Hospital:  
(Pediatrics /Internal Medicine /other specialty)

Course of illness:

● Diagnosis:

Doctor/Hospital:  
(Pediatrics /Internal Medicine /other specialty)

Course of illness:

● Diagnosis:

Doctor/Hospital:  
(Pediatrics /Internal Medicine /other specialty)

Course of illness:



Additional Information

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Additional Information

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