

Kristin Rabai, DC
3537 Thaxton Ave SE, Albuquerque, NM 87106
(505) 514-4150

Name _____ Phone-Cell: _____ Wk: _____

Address _____ City: _____ State: _____ Zip: _____

Date of Birth _____ Age _____ Gender _____ Height _____ Weight _____

Occupation _____ Email _____

Referred By _____ Family Doctor: _____

Marital Status: M S D W Committed Name of Spouse/Partner _____

Emergency Contact: _____ Phone: _____

Payment is due at the time of service.

Cancellation Policy: Please give 24 hours notice if you cannot make your scheduled appointment.
A \$45 fee will be charged for each visit. _____ (Please initial)

What are your most important health goals? Please list in order of importance to you:

1. _____ 3. _____

2. _____ 4. _____

Chief Complaint - Explain the main reason you are seeking care? _____

Duration of Present Condition _____

What do you believe caused this condition? _____

What makes it worse? _____ Better? _____

When and how did it begin? _____

On a scale from 0 (no pain) to 10 (most intense pain imaginable), please rate your pain today: _____

Rate your pain when it first began: _____ Rate your pain at its worst: _____

Do you have any arm, hand, leg, or foot pain? _____

Do you have any tingling or altered sensation? _____

Do you have weakness in any of your muscles? _____

Do you get headaches? _____ Describe: _____

When were you last seen by a physician? _____ For what purpose? _____

Doctor's Name _____ Specialty _____

Diagnosis by your doctor _____

Describe any lab work you have had done _____

Medication you are presently taking: 1. _____

2. _____ 4. _____

3. _____ 5. _____

Supplements or over-the-counter drugs you are taking:

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

Do you consider yourself: Overweight Average Underweight
Have you had any significant weight change in the last year or so? _____ Describe: _____

Are you able to work without problems? _____ Describe any limitations _____

How often do you exercise? Never Once in a while Several times/mo. Several times/wk Daily
Describe your exercise habits: _____

Have you had to cut down on your exercise because of your health? _____ Describe your hobbies and interests: _____

What is your overall satisfaction with life? _____

Are you under a lot of stress? _____ Describe: _____

What methods do you use to alleviate or cope with stress? _____

Do you suffer from exhaustion or fatigue? _____ If so, describe how you feel _____

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How often do you feel fatigue? _____ What time of day are you most tired? _____

How often do you have a bowel movement? _____ Are your stools soft or hard? _____
Do they float? _____ What color are they? _____

If you are female, do you experience menstrual problems? _____ Describe: _____

When was the date of your last menstrual period? _____ Are you, or might you be, pregnant? _____

Have you had any significant accidents, injuries, or illnesses in the past? _____ Describe (**give years and results**): _____

List any other hospitalizations or surgeries you have had. (**give years and results**): _____

Have you ever had Xrays, MRI, CAT Scan, or other imaging? _____ Please explain when, what part of body and the reason for such tests: _____

Any unusual childhood illnesses such as Scarlet Fever, Diphtheria, Rheumatic Fever, Mumps, Measles? _____

Is your mother still alive? _____ Age and cause of death: _____

Is your father still alive? _____ Age and cause of death: _____

If any of your siblings have died, please give their ages and cause of death: _____

List what kinds of diseases run in your family (ie. Heart disease, Diabetes, Strokes, Cancer, High Blood Pressure, etc.) and which relative had what: _____

List any known allergies to food, drugs, or other: _____

Have you ever taken antibiotics for a long period of time? _____

Do you use any of the following?

How much and how often?

Coffee _____

Tea _____

Alcohol _____

Chocolate _____

Laxatives _____

Sugar _____

Artificial Sweeteners _____

Antacids _____

Tranquilizers _____

Sleeping pills _____

Appetite Suppressants _____

Pain Relievers _____

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Recreational Drugs _____
Tobacco _____

Please write a number (1-5) beside each symptom that accurately describes what you are experiencing:

1=Never 2=Rarely 3=Sometimes 4=Frequently 5=Daily

Mood swings _____	Nervousness _____	Mental Tension _____	Fatigue _____
Chronic infections _____	Sensitive teeth _____	Eye pain/strain _____	Glaucoma _____
Slow wound healing _____	Psoriasis _____	Tearing/dryness _____	Impaired hearing _____
Ear ringing _____	Earaches _____	Sinus problems _____	Irritability _____
Nose bleeds _____	Sore throat _____	Teeth grinding _____	TMJ/jaw problems _____
Hay fever _____	Pneumonia _____	Common cold _____	Bleeding gums _____
Emphysema _____	Persistent cough _____	Asthma _____	Swollen lymph nodes _____
Tuberculosis _____	Shortness of breath _____	Production of phlegm _____	Chest pain _____
Swelling of ankles _____	High blood pressure _____	Palpitation/flutter _____	Stroke _____
Heart murmur _____	Varicose veins _____	High cholesterol _____	Depression _____
Ulcers _____	Belching _____	Change in appetite _____	Gallbladder disease _____
Diarrhea _____	Nausea/vomiting _____	Liver Disease _____	Constipation _____
Hepatitis B or C _____	Undigested food _____	Passing gas _____	Hemorrhoids _____
Mucous in stool _____	Heartburn _____	Abdominal pain _____	Blood in stool _____
Kidney Disease _____	Kidney stones _____	Painful urination _____	Impaired urination _____
Urinary tract infection _____	Urination at night _____	Frequent urination _____	Lack of Motivation _____
Venereal Disease _____	Vertigo/dizziness _____	Seizure/Epilepsy _____	Bloating after meals _____
Hypothyroid _____	Hypoglycemia _____	Hyperthyroid _____	Diabetes _____
Night sweats _____	Feeling hot _____	Feeling cold _____	Anemia _____
Cancer _____	Rashes _____	Eczema/hives _____	Cold hands/feet _____

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Men

Sexual difficulties____ Prostate problems____ Testicular pain/swelling____ Penile discharge____

Women

Irregular cycles____ Bleeding between cycles____ Menopausal symptoms____ Breast lumps____

Breast tenderness____ Vaginal discharge____ Difficulty conceiving____ Nipple discharge____

Clotting____ Heavy flow____ PMS____

Number of days of Menses____ Number of days between Menses____ Number of pregnancies____

Number of miscarriages____ Number of abortions____ Number of live births____

Please indicate typical food intake:

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

Drinks:_____

Any special dietary restrictions?_____

How much water do you drink a day?_____

Is your water filtered, well water, city or other?_____

Is there anything else you feel is important that I have not asked?_____

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