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

Legal Name:_____Preferred Name:_____

Phone-Cell:_____Wk:_____Home:_____

Address_____City:_____State:_____Zip:_____

Date of Birth_____Age_____M____F___Other_____Height_____Weight_____

Occupation_____Email_____

Referred By_____Family Doctor:_____

Marital Status: M S D W Committed Name of Spouse/Partner_____
EmergencyContact:_____Phone:_____

Payment is due at the time of service. Only cash and check accepted. No credit cards.

Cancellation Policy: Please give 24 hours notice if you cannot make your scheduled appointment.
A $55 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 you 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, Diptheria, 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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Sexual difficulties____ Prostate problems____ Testicular pain/swelling____ Penile discharge____

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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