Kristin Rabai, DC
4620 Robin Ave NE, Albuquerque, NM 87110
(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 $60 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__________________________

____

Name____Date of Birth_______________________

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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