PATIENT INFORMATION

Patient Name:					
	(Last)		*(First)*		*(MI)*

Email address: _____

Date of Birth: _____ Age: _____ Sex: _____

Marital Status: _____ How many children? _____

Occupation: _____

Address: _____

_____

Phone Number: (Primary) _____ (Secondary) _____

Employer: _____

Employer Address: _____

Spouse/Parent Name: _____

Referred by: _____

Emergency Contact: _____

_____

WE ARE A FEE FOR SERVICE OFFICE. ALL PAYMENTS ARE DUE AT TIME OF SERVICE.

***I AUTHORIZE THE RELEASE OF ANY MEDICAL RECORDS OR OTHER INFORMATION NECESSARY TO PROCESS CLAIMS ON MY BEHALF. I AGREE TO BE FULLY RESPOSIBLE FOR ALL LAWFUL DEBTS INCURRED BY MYSELF FOR SERVICES RECEIVED FROM DR. BRIAN L. CABIN, WHETHER COVERED BY INSURANCE OR NOT.*

_____ _____

Print Patient Name *Date of Birth*

_____ _____

Signature *Date*

MEDICAL HISTORY

Patient Name: _____ DOB: _____

Current Medications: _____

_____

_____

Vitamins & Supplements: _____

_____

Do you currently have, or have you had in the past, a history of: (Please explain)?

Allergies: _____

Respiratory Illness: _____

Frequent Infections: _____

High Blood Pressure: _____

Cancer: _____

Diabetes: _____

Heart Disease: _____

Vascular Disease: _____

Liver Disease: _____

Kidney Disease: _____

Frequent Headaches: _____

Gastrointestinal Disease: _____

Broken Bones(s):_____

Serious Accident(s):_____

Depression/Sadness: _____

Urinary Tract Disease: _____

Menstrual Problems: _____

Reproductive Disorder(s): _____

Backache: _____

Neck Pain: _____

Vision Problems: _____

Hearing Problems: _____

Abnormal weight gain/loss: _____

MEDICAL HISTORY (continued)

Patient Name: _____ DOB: _____

Feeling Out of Balance: _____

Weight/Nutritional Problems: _____

Alcohol/Drug Dependency: _____

Neurological Disorder: _____

Do you have, or have you had in the past, a close relative (Parent, Grandparent, Child, Uncle or Aunt) with the following: (Mother, Father, Son, Daughter, Grandmother, Grandfather, Uncle or Aunt etc.)

Heart Disease: _____

High Blood Pressure: _____

Diabetes: _____

Gastrointestinal Disease: _____

Depression/Sadness: _____

Headaches: _____

Asthma: _____

Allergies: _____

Cancer: _____

Aggressive Behavior: _____

Have you ever had surgery? (Please explain in detail):

_____

_____

_____

_____

_____

_____

_____

Excluding the above surgeries, have you ever been hospitalized? Please explain below:

_____

_____

_____

_____

_____

_____

_____

LIFESTYLE SURVEY

	Yes	No	Don't Know
1. I am aware of my inner stress/tension.	☐	☐	☐
2. I have difficulty relaxing.	☐	☐	☐
3. I feel that I need to do more and more in less and less time.	☐	☐	☐
4. I am often tired.	☐	☐	☐
5. I often have disturbing dreams.	☐	☐	☐
6. I smoke marijuana .	☐	☐	☐
7. I use tranquilizers.	☐	☐	☐
8. I use amphetamines or diet pills.	☐	☐	☐
9. I use some other types of non-medical drug(s).	☐	☐	☐
10. I feel that I function less than optimally due to the use of drugs.	☐	☐	☐
11. I need to become more physically active.	☐	☐	☐
12. I often eat fast foods.	☐	☐	☐
13. I binge eat.	☐	☐	☐
14. I am concerned that I may have an eating disorder.	☐	☐	☐
15. I change my eating habits based on emotions or stress.	☐	☐	☐
16. I often eat a lot of food at night before going to sleep.	☐	☐	☐
17. I have fasted.	☐	☐	☐
18. I frequently have diarrhea or constipation.	☐	☐	☐
19. I frequently have a lot of gas or abdominal pain.	☐	☐	☐
20. I often feel lonely.	☐	☐	☐
21. My emotions run my life.	☐	☐	☐
22. I usually do not feel peace of mind.	☐	☐	☐
23. It is hard for me to express my feelings.	☐	☐	☐
24. I have financial problems.	☐	☐	☐
25. I feel that "Spiritual" talk is nonsense.	☐	☐	☐
26. My family is a source of stress to me.	☐	☐	☐
27. My job is a source of stress to me.	☐	☐	☐
28. Overall, I feel a great deal of stress.	☐	☐	☐
29. I regularly eat breakfast.	☐	☐	☐
30. My diet is generally good.	☐	☐	☐
31. My job gives me satisfaction and/or a feeling of accomplishment.	☐	☐	☐
32. Overall, I am happy.	☐	☐	☐
33. I have a good self-image.	☐	☐	☐

34. I have family or close friends to help support me emotionally.	☐	☐	☐
35. I am easily able to give and receive love.	☐	☐	☐
36. I primarily feel stress in my (back, chest, neck, abdomen, stomach, etc.).	☐	☐	☐
37. To relax, I _____			
38. I have used: (circle all that apply): Meditation, yoga, breathing exercises, tai chi, aerobic exercise, self-hypnosis, other (please explain)_____			
39. I would be interested in learning more about _____ for relaxation.			
40. I sleep ____ hours per night on the average.			
41. I have smoked _____ (type of tobacco) products for _____ Years			
42. I quit smoking _____ years ago			
43. I drink _____ beers a day, _____ cola drinks a day, _____ glasses or wine a day, _____ cups of coffee a day, ____ shots of liquor a day, ____ cups of tea a day			
44. I exercise ____ times per week, doing _____ (i.e. running, swimming, etc.) for approximately _____ minutes per session.			
45. My favorite form(s) or exercise is (are) _____			
46. In a typical day, I usually eat (circle all that apply): fresh fruit, fresh vegetables, high fiber foods (such as nuts, seeds and whole grain products), dairy products, poultry, fish, beans, red meat, sweets, fried foods, refined foods (those with white flour, sugar - or such products as white rice, packaged foods, processed foods).			

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CANCELLATION POLICY

Our goal is to provide quality health care to all our patients in a timely manner. No-shows, late arrivals, and cancellations inconvenience not only our provider, but our other patients as well. Please be aware of our policy regarding missed appointments.

If cancellation is necessary, we require that you call at least **24 hours** in advance. Your advanced notice will allow another patient access to that appointment time.

A cancellation is considered late when the appointment is cancelled less than **24** hours before the appointed time. A no-show is when a patient misses an appointment without cancelling. In either case, we will charge the patient **$135.00.** For new patients' first appointments, a no show or late cancellation will result in a full charge of the new patient fee of **$275.00.**

If you need to cancel your appointment, please call us at **520-319-2810** between the hours of 8:30am to 5:00pm. If necessary, you may leave a detailed voicemail message. We will return your call as soon as possible.

Please note: We are closed on Wednesdays and the weekends.

Print Patient Name _____ DOB _____

Signature _____ Date _____