

## PATIENT INFORMATION

Patient Name:			
	<i>(Last)</i>	<i>(First)</i>	<i>(MI)</i>

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 RESPONSIBLE FOR ALL LAWFUL DEBTS INCURRED BY MYSELF FOR SERVICES RECEIVED FROM DR. BRIAN L. CABIN, WHETHER COVERED BY INSURANCE OR NOT.**

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*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):**

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

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## LIFESTYLE SURVEY

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

34. I have family or close friends to help support me emotionally.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. I am easily able to give and receive love.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36. I primarily feel stress in my (back, chest, neck, abdomen, stomach, etc.).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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).			

<b>BRIAN L. CABIN M.D., M.D.(H), P.C.</b>
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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 **\$160**. For new patients' first appointments, a no show or late cancellation will result in a full charge of the new patient fee of **\$350**.

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