Dr. Irina Riabikina, N.M.D. 4915 E Baseline Rd. #123 Phone: (480) 310-9893
Gilbert, AZ 85234

PATIENT GENERAL INFORMATION

Name:_____ Date: _____
Age:_____ Date of Birth:_____ Sex (F/M)_____
Address: _____
City:_____ State:_____ Zip Code _____
Telephone Number:_____ E-mail: _____
Occupation:_____ Hrs per week:_____ Retired _____
Employer _____
Insurance Co. _____
Educational Background _____
Are you: Married_____ Separated_____ Divorced_____ Widowed_____ Single _____
Significant Partnership: Y/N _____
Live with: Spouse_____ Partner_____ Relatives_____ Friends_____ Alone _____
In case of emergency contact:_____ Phone: _____
Another emergency contact:_____ Phone: _____

Health History Questionnaire

Dr. Irina Riabikina, N.M.D. utilizes traditional Chinese medical diagnostic and treatment methods. We treat our patients holistically on the physical, mental and emotional levels, it is therefore important to have as much information regarding your health history as is possible.

Please PRINT all information
(Mark anything you do not understand with a question mark)

When and where did you last receive health care? _____
For what reason? _____

What are your most important health problems or concerns? List as many as you can in order of importance.
1. _____
2. _____
3. _____
4. _____
5. _____

I learned about Dr. Irina Riabikina through _____
(If friend or family member, please list name)

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FAMILY HISTORY

Check those applicable	Father	Mother	Brothers	Sisters	Spouse	Child
Age (if living)	_____	_____	_____	_____	_____	_____
Health G=good P=poor	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart disease	_____	_____	_____	_____	_____	_____
High blood pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Epilepsy	_____	_____	_____	_____	_____	_____
Mental illness	_____	_____	_____	_____	_____	_____
Asthma, Hayfever, Hives	_____	_____	_____	_____	_____	_____
Anemia	_____	_____	_____	_____	_____	_____
Kidney disease	_____	_____	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____	_____	_____
Tuberculosis	_____	_____	_____	_____	_____	_____
Age (of death)	_____	_____	_____	_____	_____	_____
Cause of death	_____	_____	_____	_____	_____	_____

For the following sections, please circle Y=yes and N=no

Childhood Illness

Scarlet fever Y N Diphtheria Y N Rheumatic fever Y N
Mumps Y N Measles Y N German measles Y N
Other _____

Hospitalization and Surgery

What hospitalizations or surgeries have you had?

_____

X-rays and Special Studies

X-rays, CAT scan, or MRI's you have had:

_____
_____

Allergies

Please list any food, drugs, or other allergies:

_____
_____

Current Medications and Supplements

Do you take or use:

Laxatives	Y N	Pain relievers	Y N	Antacids	Y N
Cortisone	Y N	Appetite suppressants	Y N	Sleeping pills	Y N
Tranquilizers	Y N	Thyroid medication	Y N		

Please list prescription medications, over the counter medications, vitamins or other supplements you are taking with doses. Please specify for how long you have been taking them.

_____ How Long: _____
_____ How Long: _____
_____ How Long: _____
_____ How Long: _____
_____ How Long: _____

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HEALTH BACKGROUND

Have you ever had the following? (Yes, Past, No)

	Y	P	N		Y	P	N		Y	P	N
Anemia				Glaucoma				Mumps			
Anorexia (no appetite)				Heart Disease				Pacemaker			
Arthritis				Heart Disease				Pneumonia			
Asthma				Heart Murmur				Polio			
Back Problems				Hepatitis Type _____				Prostate Problems			
Bleeding Tendency				Hernia				Psychiatric Care			
Blood Disease				Herpes				Respiratory disease			
Cancer				High Blood Pressure				Rheumatic Fever			
Chemotherapy				HIV/AIDS				Scarlet Fever			
Chicken Pox				Jaundice				Shortness of Breath			
Chronic Fatigue Syndrome				Kidney Disease				Sinus Trouble			
Circulatory Problems				Latex Sensitivity				Skin Rash			
Congenital Heart Lesions				Liver Disease				Stroke			
Cough – persistent or bloody				Low Blood Pressure				Thyroid Problems			
Diabetes				Measles				Tonsillitis			
Drug addiction				Migraine Headaches				Tuberculosis			
Emphysema				Mitral Valve Prolapse				Ulcer			
Epilepsy				Multiple Sclerosis				Venereal Disease			

Any Other Condition (Please describe): _____

_____

Diet *(please list a typical day's diet)*

Breakfast:
Lunch:
Dinner:
Snack:

Coffee/ Tea / Soda? _____Y / N _____ How many/day? _____

Water intake: _____ Glasses per day _____

Exercise: _____Y / N _____What do you do? _____

How often /how long do you exercise? _____

_____

What expectations do you have from this visit to the Dr. Riabikina? _____

What long term expectations do you have from working with Dr. Riabikina? _____

_____

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CONSENT FOR TREATMENT

Dr. Irina Riabikina, N.M.D. is a primary health care physician that uses a variety or therapies including acupuncture, IV therapy, herbal medicine, homeopathy, and nutritional supplementation. I understand that certain modalities of care I will receive are not considered to be primary health care modalities in the state of Arizona.

If my treatment includes acupuncture, I understand that the potential benefits of acupuncture include drugless relief of my symptoms and an improved state of health. I understand that the potential risks of acupuncture include local discomfort and bruising, with a potential for infection at the site of the needle insertion.

In addition I understand that I may be prescribed herbs and nutritional supplements to take to help relieve my condition. I understand that nutritional supplements and herbal formulas are not regulated in the state of Arizona and that under rare circumstances people experience certain side effects from their use.

With my understanding of the above, I voluntarily consent to receive alternative treatments.

Signature of patient (or a person authorized to provide consent): _____

Date: _____

AGREEMENT OF CANCELLATION

Dr. Irina Riabikina has a 24 hours cancellation policy. I understand that if I cancel my appointment for any reason in less than 24 hours, I will be charged a $35 dollars cancellation fee.

Signature of patient (or a person authorized to provide consent): _____

Date: _____