

R A N I C K I Chiropractic ♦ Wellness Center

Personal information – Please fill in completely

Date: ____/____/____

Name _____ Birth Date ____/____/____ Age ____ Male ___ Female ___

Social Security # _____ Driver's License # _____ Spouse's Name _____

Address _____

Street

City

State

zip code

Home Telephone # _____ Alternate Telephone # _____ (c), (w)

Email address _____ Do you have Medicare or Medicaid benefits? Yes No

Employer _____ What type of work do you do? _____

Who may we thank for referring you to our office? _____

Emergency Contact and number _____

Primary Care Provider/Affiliation _____

HEALTH PROFILE

What would you most like to see improve in your health or quality of life? _____

How long have you had these problems? _____

What do you think may have led to these problems? _____

Is there anything your health prevents you from doing or is there anything your health makes you do that you would rather not?

What are your favorite pastimes? _____

Does this health problem make these activities more difficult or less enjoyable? How? _____

What other things would you like to see improve in your health or quality of life _____

Do you need assistance with diet, exercise, and stress release recommendations? Which? _____

Have you ever been seen by a Doctor of Chiropractic before? Yes No Who _____ Where _____

Have you had any surgeries? Type and approximate year _____

Is there anything else about you or your health that you feel we need to know _____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Signature

Date