RUGGIERO FAMILY CHIROPRACTIC
& REHABILITATION CENTER, LLC

1047 MAIN STREET, MANCHESTER, CT 06040
TEL: 860-643-2888 www.ruggierofamilychiro.com FAX: 860-643-2872

Client Information (All information is completely confidential) Please Print Clearly

Name: _____Date: _____

Cell Phone #: _____

Address: _____City/Zip: _____

Date of Birth: _____ Marital Status: S M W D # Children: _____

Occupation: _____

Email Address: _____

Purpose of this session: _____

Fears/Phobias? Please List: _____

Ever been treated for: Diabetes – Epilepsy – Heart Disorder – Digestive Problems – Emotional Issues

Are you presently under a doctor's care? Yes No

Explain:_____

_____

I have your permission to contact your physician if it is appropriate. _____ (Initials)

Quality of life for today: Excellent Fine Just OK Not Good

Quality of life this past week: Excellent Fine Just OK Not Good

Do you generally sleep through the night? Excellent Fine Just OK Not Good

Do you generally waken feeling refreshed? Excellent Fine Just OK Not Good

Pain level today (1-10; 10 unbearable): 1 2 3 4 5 6 7 8 9 10

Pain during this past week: 1 2 3 4 5 6 7 8 9 10

Referred by: _____

Emergency Contact: Name: _____Phone: _____

I understand that Reconnective Healing® and the Reconnection® energy healing is not a substitute for medical or psychological diagnosis and treatment. I also understand that Reconnective Healing Practitioners do not diagnose conditions, do not prescribe or perform medical or psychological treatment, and do not interfere with the treatment of licensed medical or psychological professionals. I am willing to participate in Reconnective Healing®/the Reconnection® for relaxation and for the purposes of self-improvement. It is recommended that I see a licensed physician or health care professional for any physical or psychological ailments I might have.

Signature: _____Date:

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