"3John2"

RAPHA CLINIC

RAPHA-CLINIC.COM

YOUR INFORMATION

Thank you for choosing Rapha Clinic for your health needs.
We look forward to serving you to the best of our ability. Please complete this form in ink.
If you have any questions or concerns, please ask for assistance. We will gladly help.

Date: _____/_____/_____ Email: _____

_____ _____ _____
Last Name First Name M. I.

_____ _____ _____ _____
Current Address City State Zip

Home Phone #: ( )_____ Cell Ph #: ( )_____

_____ ____/____/____ _____ Sex: Male Female
Social Security # Birth Date Age

Are you: Minor Married Divorced Widowed Single Separated

_____ _____ (____)_____
Name of Employer Occupation Work Phone #

_____ _____ _____ _____
Employer's Address City State Zip

_____ _____ (____)_____
Contact in case of Emergency Relationship Phone #

Whom may we thank for referring you to us? _____

DAILY HABITS

What type of exercise do you perform on a daily basis? ☐ None ☐ Moderate ☐ Heavy
What physical activities does your daily work include? (E.g. sitting, standing, light labor, heavy labor, computer work)_____
What vitamins do you currently take? _____
What other kind of nutritional supplements do you take? (If any)_____
Do you smoke? ☐ No ☐ Yes How much per day? _____
How much alcohol do you drink in a typical week? _____
How much coffee or other caffeinated beverages do you drink on a typical day? _____