RJF Consulting

EXPERIENCE ◆ INTEGRITY ◆ RESULTS

A Different Approach To Practice Management

Preliminary Confidential Client Questionnaire

This and all future communications will be kept confidential.

(Please Print)

Full Name____

Office Address ____

City ______________________ State _____________ Zip ____________

Office Phone ________________________ Cell _____________________

Email ______________________________

Pre-Chiropractic Education ____

Chiropractic College __________________________ Year Graduated _______

Years in Practice __________________ How long in present location? ______

Have you ever had your license revoked or suspended? Yes No

Describe your practice? ____

Do you currently work with a practice management firm? Yes No

Number of Professionals at your clinic?

DCs: MDs/DOs: PTs: LMTs: CAs:

MONTHLY AVERAGE (last 12month average)

Office Visits/month: ______ New Patients/month: ______ Collections/month: ______

List your practice management issues in prioritized order:

Fax or email this completed form to: 1-888-809-4648 or info@chiroevidence.com