Welcome to Davenport Family Chiropractic

Name: _____ Date: _____

Tell us about yourself:

Address: _____

City, State, Zip _____

Home Phone: _____ Cell Phone: _____Occupation: _____

E-Mail Address: _____Employer: _____

Birth date: _____

How did you hear about our office? _____

Past Chiropractic Care? ☐ Yes ☐ No If so, Where/When? _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Tell us about your family (if applicable):

Spouse's Name: _____ Spouse's Occupation: _____

Names/Ages of children at home: _____

Tell us the main reason you came to our office: _____

If you have a symptom(s) that concerns you: _____

How long has it bothered you? _____

Any idea what caused it? _____

Describe it at its worst: _____

_____

Is this problem affecting your: ☐ Work? ☐ Family/social life? ☐ Hobbies? ☐ Daily routine? ☐ Sleep? ☐ Travel?

How committed are you to getting this problem solved? *(circle one)* 1 2 3 4 5 6 7 8 9 10
just a little *very much*

As of Today:

Rate your symptoms: ☹ *(bad)* 0 1 2 3 4 5 6 7 8 9 10 *(no symptoms)* ☺

Rate your overall health: ☹ *(bad)* 0 1 2 3 4 5 6 7 8 9 10 *(excellent)* ☺

Tell us about your Health Goals: *Mark all that apply…*

❑ get rid of symptoms ❑ reduce medication ❑ lose/gain weight

- ❑ keep symptoms away
- ❑ reduce stress
- ❑ live longer
- ❑ improve overall health
- ❑ improve immune system
- ❑ improve the quality of my life
- ❑ Other Health Goals: _____ _____

Brief Health History

Tell us about:

…any *accidents or injuries* you've ever had: _____

_____

…any *surgery or major medical procedures* you've ever had: _____

_____

…any *major or recurring illness* you've had or have now: _____

_____

Are you currently under medical care? □ Yes □ No Condition: _____

List any medications *(prescription or Over-the Counter)* you are currently taking:_____

_____

How is your overall health and well-being? Mark any symptoms you've had in the past six months:

- ❑ Headaches
- ❑ Migraines
- ❑ Low Energy
- ❑ Pain/Tension
- ❑ Reflux
- ❑ Digestive Problems
- ❑ Irregularity
- ❑ Nervousness
- ❑ Irritability
- ❑ Dizziness
- ❑ Allergies
- ❑ Seasonal
- ❑ Food
- ❑ Difficulty Sleeping
- ❑ Asthma
- ❑ Other Health Concerns: _____ _____ _____

Tell us about your lifestyle:

Do you have significant mental stress in your: □ job □ home □ family □ other

How much *water* do you drink each day? □ 8 oz □ 16 oz □ quart □ 2 quarts □ not sure

Do you drink: □ diet drinks *(Nutrasweet)* □ coffee/tea *(caffeine)* □ alcohol
How much? *never some lots* *never some lots* *never some lots*

Do you: □ stretch □ exercise □ run/walk □ lift weights
How much? never some lots never some lots never some lots never some lots

"This time, like all times, is a very good one…if we but know what to do with it."

Ralph Waldo Emerson