Welcome to Davenport Family Chiropractic

Name: _____ DOB:_____ Date: _____

Tell us about yourself:

Address: _____

City: _____ State: _____ Zip: _____

Cell Ph: _____ Home Ph: _____ Occupation: _____

Email: _____ Employer: _____

How did you hear about our office:

_____

Past Chiropractic Care? ☐ Yes ☐No If Yes, 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 about your symptoms:

What is the main reason you came to our office:

_____

Do you have symptoms that concern you?

_____

How long has it bothered you?

_____

Any idea what caused it?

_____

Describe it at its worst: _____

Is this problem affecting your: (check all that apply) ☐ Work ☐ Family/social life ☐Hobbies

☐ Daily Routine ☐ Sleep ☐ Travel

How committed are you to getting this problem solved? (*Circle one*) Just a little 1 2 3 4 5 6 7 8 9 10 Very Much

Rate your symptoms: 0 1 2 3 4 5 6 7 8 9 10 None Severe Rate your overall health: 0 1 2 3 4 5 6 7 8 9 10 Poor Excellent

Health Goals: (*circle all that apply to you*)

*Getting rid of symptoms *Live longer *Reduce stress *Reduce medication

*Improve overall health *Lose/gain weight *Improve immune system *Keep symptoms away
*Improve quality of 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 from a physician? ☐Yes ☐No
Condition:

_____

List any medications (prescription or over-the-counter) you are taking:

_____

_____

Pregnancy Release (*Women only*)
I certify to the best of my knowledge I am **NOT pregnant**, and Dr. Jeffrey Davenport and/or his associates have my permission to perform any x-ray evaluation if needed. I have been advised that x-ray can be hazardous to an unborn child.
Date of last menstrual period: _____

Signature: _____ **Printed name:** _____

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

*Headaches	*Irregularity	*Food Issues	*Migraines	* Nervousness
*Difficulty Sleeping	*Low Energy	*Irritability	*Asthma	*Pain/Tension
*Dizziness	*Reflux	*Allergies	*Seasonal	*Digestive problems

*Other Health Concerns: _____

Tell us about your lifestyle: (check all that apply)

Do you have significant mental stress in your ☐Job ☐Home ☐Family ☐Other

How much water do you drink per day? ☐ 8 oz ☐ 16 oz ☐ quart ☐ 2 quarts ☐ not sure

Indicate how much you drink of the items below:

Diet drinks (NutraSweet/Splenda etc.): ☐ Never ☐ Some ☐ Frequent

Coffee/tea(caffeine): ☐ Never ☐ Some ☐ Frequent Alcohol: ☐ Never ☐ Some ☐ Frequent

Do you? (*check all that applies*)
Stretch - ☐ Never ☐ Some ☐ Frequent Exercise - ☐ Never ☐ Some ☐ Frequent

Run/walk - ☐ Never ☐ Some ☐ Frequent Lift weights - ☐ Never ☐ Some ☐ Frequent