Personal History Form

Name_____ Date _____

The following is a confidential questionnaire which will help us determine the best possible course of treatment for you. Please take your time and complete the information accurately. Thank you!

How would you describe your chief complaint at this time?

_____

_____

When did it start?_____
(Include month and year, day if known)

What makes the pain worse? _____

What makes the pain better? _____

How would you describe your pain? _____

At what time of the day or week is your pain worse? _____

The pain is: ___ Intermittent ___ Constant

Have you had this problem in the past? _____ If so, how often? _____

Is your pain the result of a motor vehicle accident? _____

Have you filed a legal suit? _____

Is your pain the result of a work related injury? _____

If so, have you filed a worker's compensation claim? _____

Please list accidents, injuries, surgeries, and hospitalizations you have had.

_____ Date or Age _____

_____ Date or Age _____

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New Britain Chiropractic, William Z Polsky DC, Jeanne M Sharpe DC
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Phone: 215-340-2797 Fax: 215-340-2231

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Do you or other family members have a history of any of the following?

_____Arthritis	__ Self	Family member _____
_____Cancer	__ Self	Family member _____
_____Diabetes	__ Self	Family member _____
_____Heart Disease	__ Self	Family member _____
_____Hypertension	__ Self	Family member _____
_____Hypoglycemia	__ Self	Family member _____
_____Kidney Disease	__ Self	Family member _____
_____Depression	__ Self	Family member _____
_____Mental Illness	__ Self	Family member _____
_____Stroke	__ Self	Family member _____

Do you drink coffee or black tea? _____ If so, how much per day? _____

Do you smoke tobacco? _____ If so, how much per day? _____

Do you drink alcohol? _____ If so, how often? _____

How many times a week do you engage in physical activity that is sufficiently prolonged and intense to cause sweating and raise you heart rate?_____

When you engage in the physical activity noted above, what is the average duration of activity?
____ Less than 10 minutes ____ 10 – 20 mins ____ 20 – 30 mins ____ 30 – 60 mins ____ over 60 mins

At work, how many days per week do you engage in tasks that are intense enough to cause sweating and a rapid heart rate?
_____

Please rate your level of fitness (0 = very poor, 5 = average, 10 = excellent) _____

What medications, vitamins, supplements, herbs do you take?

Name	**Reason**
_____	_____
_____	_____
_____	_____
_____	_____

Please list any allergies that you have:

_____

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