Bordentown Chiropractic Clinic
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231 Crosswicks Rd, Suite 1A
Bordentown, NJ. 08505

Patient Health History Worksheet

Patient Name:____ Date:_________________________________

Present Health History

When did your present condition begin?
a) Gradual Onset (no specific date)
b) Date:______________________

What caused your present condition?
a).No specific injury
b).Home Accident
c) Work Accident
d) Auto Accident

What happened to cause your present condition?
____
____
____

Have you ever had these symptoms before?
a) No
b) Yes: (Date:_________________________)

What time of day are your symptoms *better*?
a) Morning
b) Afternoon
c) Evening
d) None of the above (constant pain)

What time of day are symptoms *worse*?
a) Morning
b) Afternoon
c) Evening
d) None of the above (constant pain)

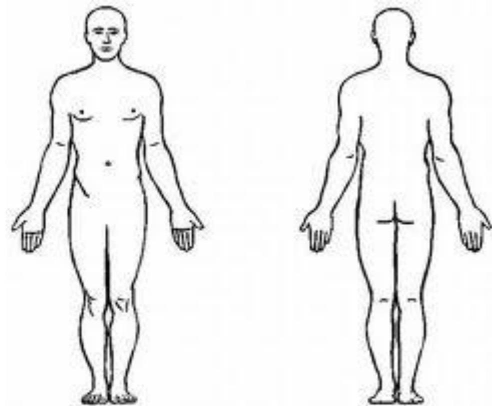
Have you missed any work from this condition?
a) No
b) Yes: (Date:__________________)

What makes your pain better?
a) Rest
b) Ice packs/Heating Pads
c) Prescription Medications
d) Drug Store medications (ibuprofen, Advil)
e) Other:________________________

What makes your pain *worse*?
a) Activity (work, repetitive motions)
b) Ice Packs/Heating pads
c) Driving (or riding) in car
d) Other:_________________________________
____

What home remedies have you tried?
a) Ice Packs
b) Heating pads/Hot tubs
c) Exercise
d) Other:_________________________________
____

Please Label The Area(s) Of Today's Pain



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Patients Name____**Date:**___________________

Significant Past Health History S

Have you ever been hospitalized?

a) No

b) Yes: (Year:____________) (Reason:____________)

Have you had any surgeries?

a) No

b) Yes: (Year:____________) (Reason:____________)

Do you have any significant health problems?

a) No

b) Yes: (_______________________________________)

Significant Past Medical History

Have you seen another doctor for this condition?

A) No

B) Yes: (Name:_________________________________)

Did this doctor recommend any treatment?

a) No

b) Yes: (_______________________________________)

Are you taking any medications?

a) No

b) Yes: (_______________________________________)

Significant Past Social History

Do you play any sports or exercise?

a) No

b) Yes: (_______________________________________)

How many hours do you sleep a night? (__________)

How many hours a week do you work? (__________)

Significant Family Medical History

Did your father have any health problems?

a) No

b) Yes: (_______________________________________)

Did your mother have any health problems?

a) No

b) Yes: (_______________________________________)

Did your brother(s) have any health problems?

a) No

b) Yes: (_______________________________________)

Did your sister(s) have any health problems?

a) No

b) Yes: (_______________________________________)

Did your Grandfather have any health problems?

a) No

b) Yes: (_______________________________________)

Did your Grandmother have any health problems?

a) No

b) Yes: (_______________________________________)

Health Risk Factors

Do you drink alcohol?

a) No

b) Yes: (_______________________________________)

Do you smoke?

a) No

b) Yes: (_______________________________________)

Anything else the doctor should know about?

a) No

b) Yes: (_______________________________________)