

EAST EARL CHIROPRACTIC, 4607 DIVISION HIGHWAY, EAST EARL, PA 17519  
APPLICATION FOR CHIROPRACTIC CARE & CONFIDENTIAL CASE HISTORY

NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_  
 ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_ ZIP \_\_\_\_\_  
 HOME PHONE # \_\_\_\_\_ WORK # \_\_\_\_\_ CELL # \_\_\_\_\_  
 OCCUPATION \_\_\_\_\_ EMPLOYER \_\_\_\_\_  
 SOCIAL SECURITY NUMBER \_\_\_\_\_ MARITAL STATUS (CIRCLE 1):    S   M   D   W  
 SPOUSE \_\_\_\_\_ # OF CHILDREN \_\_\_\_ REFERRED BY \_\_\_\_\_  
 SPOUSE'S OCCUPATION \_\_\_\_\_ EMPLOYER \_\_\_\_\_  
 NAME OF INSURANCE COMPANY \_\_\_\_\_ PHONE # \_\_\_\_\_  
 ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_ ZIP \_\_\_\_\_  
 POLICY # \_\_\_\_\_ NAME OF INSURED \_\_\_\_\_

TYPE OF COVERAGE (CIRCLE 1):    GROUP    PERSONAL    ACCIDENT    INDUSTRIAL    MEDICARE  
 PLEASE DESCRIBE YOUR MAJOR COMPLAINTS: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

IS THIS CONDITION DUE TO (CIRCLE 1)?    PERSONAL INJURY    ON-THE-JOB INJURY    AUTO-ACCIDENT  
 IS THIS THE RESULT OF A SPECIFIC INCIDENT (EXPLAIN) \_\_\_\_\_  
 WHEN DID IT START? \_\_\_\_\_ HAVE YOU EVER HAD THIS CONDITION BEFORE?    Y   N  
 IF YES, PLEASE DESCRIBE: \_\_\_\_\_  
 IS THIS CONDITION GETTING WORSE (CIRCLE 1)?:    YES    NO    CONSTANT    COMES AND GOES  
 IF SO, WHAT ACTIVITIES MAKE IT WORSE? \_\_\_\_\_  
 DOES THIS CONDITION INTERFERE WITH (CIRCLE 1)?:    WORK    SLEEP    DAILY ACTIVITY    OTHER \_\_\_\_\_  
 HAVE YOU DONE ANYTHING TO TREAT THIS CONDITION? \_\_\_\_\_  
 DIAGNOSIS: \_\_\_\_\_  
 RESULTS (CIRCLE 1):    GOOD    FAIR    POOR    NONE

Please check the appropriate box for any of the following symptoms, which you have or have had previously.  
 We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> NECK PAIN, STIFFNESS, GRATING, OR TENSION (CIRCLE 1)     | <input type="checkbox"/> NERVOUSNESS, DEPRESSION OR MENTAL DISORDERS (CRICLE 1) | <input type="checkbox"/> RINGING IN THE EARS OR EAR TROUBLES (CIRCLE 1) | <input type="checkbox"/> MENOPAUSAL SYMPTONS                |
| <input type="checkbox"/> MID-BACK PAIN, STIFFNESS, GRATING OR TENSION (CIRCLE 1)  | <input type="checkbox"/> CONVULSIONS  | <input type="checkbox"/> HIGH OR LOW BLOOD PRESSUE (CIRCLE 1)           | <input type="checkbox"/> LUMOPS IN BREAST                   |
| <input type="checkbox"/> LOW BACK PAIN, STIFFNESS, GRATING, OR TENSION (CIRCLE 1) | <input type="checkbox"/> BAD MOODS & BEHAVIOR                                   | <input type="checkbox"/> CHEST PAINS                                    | <input type="checkbox"/> COLS, FLU, OR PNEUMONIA (CIRCLE 1) |
| <input type="checkbox"/> SHOULDER PAIN OR NUMBNESS (CIRCLE 1)                     | <input type="checkbox"/> TREMORS  | <input type="checkbox"/> POOR CIRCULATION                               | <input type="checkbox"/> ALCOHOLISM                         |
| <input type="checkbox"/> ARM PAIN OR NUMBNESS (CIRCLE 1)                          | <input type="checkbox"/> INSOMNIA   | <input type="checkbox"/> CHRONIC COUGH                                  | <input type="checkbox"/> ANEMIA                             |
| <input type="checkbox"/> HAND PAIN OR NUMBNESS (CIRCLE 1)                         | <input type="checkbox"/> SWEATS OR CHILLS (CIRCLE 1)                            | <input type="checkbox"/> DIFFICULTY BREATHING                           | <input type="checkbox"/> ARTERIO-SCLEROSIS                  |
| <input type="checkbox"/> HIP PAIN OR NUMBNESS (CIRCLE 1)                          | <input type="checkbox"/> COLON TROUBLE  | <input type="checkbox"/> SKIN ERUPTIONS                                 | <input type="checkbox"/> ARTHRITIS                          |
| <input type="checkbox"/> LEG PAIN OR NUMBNESS (CIRCLE 1)                          | <input type="checkbox"/> BELCHING/GAS   | <input type="checkbox"/> VARICOSE VEINS                                 | <input type="checkbox"/> CANCER                             |
| <input type="checkbox"/> FOOT PAIN OF NUMBNESS (CIRCLE 1)                         | <input type="checkbox"/> CONSTIPATION, DIARRHEA, OR INDIGESTION (CIRCLE 1)      | <input type="checkbox"/> ACNE   | <input type="checkbox"/> CROUP                              |
| <input type="checkbox"/> PAINFUL TAIL BONE  | <input type="checkbox"/> HEMORRHOIDS  | <input type="checkbox"/> BOILS  | <input type="checkbox"/> DIABETES                           |
| <input type="checkbox"/> SCIATICA   | <input type="checkbox"/> STOMACH ACHES, NAUSEA OR VOMITING (CIRCLE 1)           | <input type="checkbox"/> ITCHING  | <input type="checkbox"/> EPILEPSY                           |
| <input type="checkbox"/> PAINFUL OR SWOLLEN JOINTS (CIRCLE 1)                     | <input type="checkbox"/> GALL BLADDER TROUBLE                                   | <input type="checkbox"/> BED WETTING                                    | <input type="checkbox"/> HEART DISEASE                      |
| <input type="checkbox"/> BURSTITIS  | <input type="checkbox"/> LIVER TROUBLE  | <input type="checkbox"/> BLOOD IN URINE                                 | <input type="checkbox"/> MISCARRIAGE                        |
| <input type="checkbox"/> HERNIA   | <input type="checkbox"/> ASTHMA   | <input type="checkbox"/> FREQUENT OR PAINFUL URINTATION (CIRCLE 1)      | <input type="checkbox"/> MULTIPLE SCLEROSIS                 |
| <input type="checkbox"/> PINCHED NERVES   | <input type="checkbox"/> ALLERGIES, SINUS, OR HAY FEVER (CIRCLE 1)              | <input type="checkbox"/> KIDNEY OR PROSTATE TROUBLE (CIRCLE 1)          | <input type="checkbox"/> POLIO                              |
| <input type="checkbox"/> HEADACHES OR MIGRAINES (CIRCLE 1)                        | <input type="checkbox"/> TONSILLITIS OR SORE THROAT (CIRCLE 1)                  | <input type="checkbox"/> MENSTRUAL CRAMPS OR EXCESSIVE FLOW (CIRCLE 1)  | <input type="checkbox"/> STROKE                             |
| <input type="checkbox"/> DIZZINESS OR FAINTING (CIRCLE 1)                         | <input type="checkbox"/> EYE PAIN OR FAILING VISION (CIRCLE 1)                  | <input type="checkbox"/> IRREGULAR CYCLE                                | <input type="checkbox"/> T.B.                               |