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

NAME _____ BIRTHDATE _____ AGE_____
STREET ADDRESS _____ CITY _____ STATE ____ ZIP _____
HOME PHONE # _____ WORK # _____ CELL # _____
OCCUPATION _____ EMPLOYER _____
SOCIAL SECURITY NUMBER _____ MARITAL STATUS S/M/D/W (CIRCLE 1)
SPOUSE _____ # OF CHILDREN _____ REFERRED BY _____
SPOUSE'S OCCUPATION & EMPLOYER _____
NAME OF INSURANCE COMPANY _____
MAJOR COMPLAINTS _____
_____
IS THIS CONDITION DUE TO A SPECIFIC INJURY? PERSONAL/AT WORK/AUTO ACCIDENT (CIRCLE 1)
WHEN DID IT START? _____ HAVE YOU EVER HAD IT BEFORE? _____
IS IT GETTING WORSE? _____ IF YES, WHAT MAKES IT WORSE? _____
DOES IT INTERFERE WITH DAILY ACTIVITIES? IF YES, WHICH ONES? _____
HAVE YOU DONE ANYTHING TO TREAT IT YOURSELF? _____
HAVE YOU CONSULTED ANY OTHER PHYSICIANS? _____
IF YES, DIAGNOSIS: _____ RESULTS _____

Please indicate which of the following symptoms you now have or have had previously.

___ Neck pain, stiffness, grating, or tension	___ Mid-back pain, stiffness, grating, or tension	
___ Low back pain, stiffness, grating, or tension	___ Shoulder pain or numbness	
___ Arm pain or numbness	___ Hand pain or numbness	___ Hip pain or numbness
___ Leg pain or numbness	___ Foot pain or numbness	___ Painful tailbone
___ Sciatica	___ Painful or swollen joints	___ Bursitis
___ Hernia	___ Pinched nerves	___ Headaches or migraines
___ Dizziness or fainting	___ Shortness of breath	___ Heart problems
___ Chest pain	___ Ulcer	___ Peripheral/Vascular Disease/Stroke
___ Allergies/Hay Fever	___ Asthma/Respiratory issues	___ GI Disorder
___ Diabetes	___ Digestive Laboratories	___ Sexual/Reproductive Issues
___ Infectious Diseases	___ Anemia	___ Arthritis
___ High blood pressure	___ Osteoporosis	___ Psychiatric disorders
___ Tuberculosis	___ Childhood diseases	___ Vision issues
___ Hearing issues/ringing in the ears	___ Cancer	___ Epilepsy/convulsions/tremors

___ Other (please describe) _____

Tobacco use _____ Alcohol use _____ Drug use _____

FAMILY HISTORY	Father	Mother	Fathers' Parents	Mothers' Parents	Siblings	Children
Heart Disease	◯	◯	◯	◯	◯	◯
High Blood Pressure	◯	◯	◯	◯	◯	◯
Stroke	◯	◯	◯	◯	◯	◯
Cancer	◯	◯	◯	◯	◯	◯
Glaucoma	◯	◯	◯	◯	◯	◯
Diabetes	◯	◯	◯	◯	◯	◯
Epilepsy/Convulsions	◯	◯	◯	◯	◯	◯
Bleeding Disorder	◯	◯	◯	◯	◯	◯
Kidney Disease	◯	◯	◯	◯	◯	◯
Thyroid Disease	◯	◯	◯	◯	◯	◯
Mental Illness	◯	◯	◯	◯	◯	◯
Osteoporosis	◯	◯	◯	◯	◯	◯