Dr. Mark T. Spratford
Doctor of Chiropractic

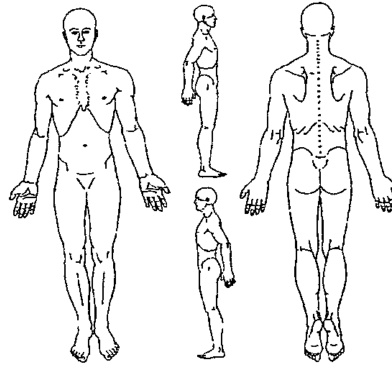
736 Mountain Blvd.
Watchung, NJ 07069
908-754-6888

Please fill out and Print and Bring to the office with you or Click Submit.

if you have a Mac save file and send attachment

Name		DOB		Home Phone	
Address		Cell		Work Phone	
City		State		Zip Code		S. S. #	
Marital Status		Emergency Contact		Emerg Contact #	
Employer		Occupation		Email	
Address		City, State, Zip			
Whom May We Thank for your Referral		Private Physician			

- ☐ Headache
- ☐ Neck Pain
- ☐ Upper/ Mid Back Pain
- ☐ Low Back Pain
- ☐ Shoulder/ elbow/ wrist/ hand pain
- ☐ Hip/ Knee/ leg/ foot/ ankle pain
- ☐ other



USE THE LETTERS LISTED BELOW TO INDICATE THE *TYPE* AND *LOCATION* OF YOUR PAIN AND SENSATIONS...

KEY
A = ACHE
B = BURNING
S = STABBING
N = NUMBNESS
P = PINS & NEEDLES
O = OTHER

	YES	NO
* Arthritic Condition	☐	☐
* Cancer	☐	☐
* Diabetes	☐	☐
* Heart Problems	☐	☐
* High Blood Pressure	☐	☐
*Vascular Condition	☐	☐
*Lung Problems	☐	☐
*Usual Childhood Diseases	☐	☐
*Unusual Childhood Diseases	☐	☐
*Currently Pregnant	☐	☐
*Smoker	☐	☐
*Alcohol	☐	☐
*Exercise Regularly	☐	☐
*Allergies	☐	☐
*Birth Control Medications	☐	☐

List Medications:

Allergic to Medications:

Allergies:

Height: Weight:

List Surgeries/ Hospitalizations:

If any other, please explain:

☐ Specific Injury? (Check if Yes)	Date of Injury		☐ Previous Treatment? (Check if Yes)	Treatment Type:	
Doctor Name:		Phone #		Nature of Injury	

Auto: Complete Sections 1 & 3 only   Work-Related: Complete Sections 2 & 3 only   Home/Other: Complete Section 3 only

Section 1: Personal Injury

Date		Time		Location of Accident	
☐ Auto Vs. Auto	☐ Auto Vs. Truck	☐ Motorcycle	☐ Auto Vs. Bus	☐ Auto Vs. Pedestrian	☐ Slip & Fall
Other:		Please Describe Injury			
☐ Driver or ☐ Passenger	☐ Front Seat or ☐ Back Seat	☐ Wearing Seat belt or Shoulder Harness? (Check if Yes)	☐ Body Parts Struck? (Check if Yes)		
If Yes, Please List:		☐ Emergency Treatment? (Check if Yes)	If Yes, Where?		
☐ Work-Related? (Check if Yes)	☐ If Yes, any work loss?	☐ Loss of Consciousness?	☐ Were You Bleeding?	☐ X-Rays Taken?	If Yes, List Areas:

Section 2: Workers' Compensation Injury/ Employer Information

Company Name			
Address		City, State, Zip	
Type of Business		Occupation	
Time of Injury:	Date Last Worked:	Date of Injury:	
Injured At (Location, Street, City, State)		Please Describe Injury:	

Section 3: Insurance Information/ Method of Payment

Method of Payment		☐ General Health Insurance	☐ Workers' Compensation Insurance	☐ Auto Insurance	
Insurance Company		Claim Representative			
Policy/ID #		Group #		Claim #	
Address		City, State, Zip		Phone #	
Name of Insured		Social Security #		☐ Self or ☐ Other	
Auto Med- Pay Insurance Company		Policy Number			

Authorization to Release Medical Information/ Financial Agreement:
I hereby authorize this office to release any information requested by my insurance company to document my claim for benefits. I understand that I am personally responsible for full payment of all charges for my treatment. Services are payable at the time rendered.

Signature: ______________________________   Date: __________________