

Dr. Mark T. Spratford Doctor of Chiropractic

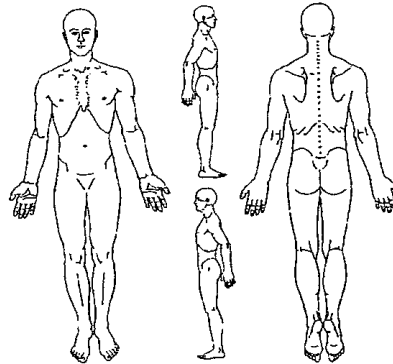
736 Mountain Blvd.
Watchung, NJ 07069
908-754-6888

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	<input type="text"/>	DOB	<input type="text"/>	Home Phone	<input type="text"/>		
Address	<input type="text"/>		Cell	<input type="text"/>	Work Phone	<input type="text"/>	
City	<input type="text"/>	State	<input type="text"/>	Zip Code	<input type="text"/>	S. S. #	<input type="text"/>
Marital Status	<input type="text"/>	Emergency Contact	<input type="text"/>		Emerg Contact #	<input type="text"/>	
Employer	<input type="text"/>		Occupation	<input type="text"/>		Email	<input type="text"/>
Address	<input type="text"/>		City, State, Zip	<input type="text"/>			
Whom May We Thank for your Referral	<input type="text"/>			Private Physician	<input type="text"/>		

<input type="checkbox"/> Headache
<input type="checkbox"/> Neck Pain
<input type="checkbox"/> Upper/ Mid Back Pain
<input type="checkbox"/> Low Back Pain
<input type="checkbox"/> Shoulder/ elbow/ wrist/ hand pain
<input type="checkbox"/> Hip/ Knee/ leg/ foot/ ankle pain
<input type="checkbox"/> 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

	YES	NO
* Arthritic Condition	<input type="checkbox"/>	<input type="checkbox"/>
* Cancer	<input type="checkbox"/>	<input type="checkbox"/>
* Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
* Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>
* High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
*Vascular Condition	<input type="checkbox"/>	<input type="checkbox"/>
*Lung Problems	<input type="checkbox"/>	<input type="checkbox"/>
*Usual Childhood Diseases	<input type="checkbox"/>	<input type="checkbox"/>
*Unusual Childhood Diseases	<input type="checkbox"/>	<input type="checkbox"/>
*Currently Pregnant	<input type="checkbox"/>	<input type="checkbox"/>
*Smoker	<input type="checkbox"/>	<input type="checkbox"/>
*Alcohol	<input type="checkbox"/>	<input type="checkbox"/>
*Exercise Regularly	<input type="checkbox"/>	<input type="checkbox"/>
*Allergies	<input type="checkbox"/>	<input type="checkbox"/>
*Birth Control Medications	<input type="checkbox"/>	<input type="checkbox"/>

List Medications:

Allergic to Medications:

Allergies:

Height: Weight:

List Surgeries/
Hospitalizations:

If any other, please explain:

<input type="checkbox"/> Specific Injury? (Check if Yes)	Date of Injury	<input type="checkbox"/> 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			
<input type="checkbox"/> Auto Vs. Auto	<input type="checkbox"/> Auto Vs. Truck	<input type="checkbox"/> Motorcycle	<input type="checkbox"/> Auto Vs. Bus	<input type="checkbox"/> Auto Vs. Pedestrian	<input type="checkbox"/> Slip & Fall
Other:	Please Describe Injury				
<input type="checkbox"/> Driver or	<input type="checkbox"/> Passenger	<input type="checkbox"/> Front Seat or	<input type="checkbox"/> Back Seat	<input type="checkbox"/> Wearing Seat belt or Shoulder Harness? (Check if Yes)	<input type="checkbox"/> Body Parts Struck? (Check if Yes)
If Yes, Please List:	<input type="checkbox"/> Emergency Treatment? (Check if Yes)	If Yes, Where?			
<input type="checkbox"/> Work-Related? (Check if Yes)	<input type="checkbox"/> If Yes, any work loss?	<input type="checkbox"/> Loss of Consciousness?	<input type="checkbox"/> Were You Bleeding?	<input type="checkbox"/> 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	<input type="checkbox"/> General Health Insurance	<input type="checkbox"/> Workers' Compensation Insurance	<input type="checkbox"/> Auto Insurance
Insurance Company	Claim Representative		
Policy/ID #	Group #	Claim #	
Address	City, State, Zip	Phone #	
Name of Insured	Social Security #	<input type="checkbox"/> Self or	<input type="checkbox"/> 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: _____