SPARKS CHIROPRACTIC

Last Name:_____ First Name:_____ Middle:_____

Home Phone:_____ Work Phone:_____ Cell:_____

Email Address:_____

Street Address & Number:_____

City, State & Zip:_____

Mailing Address:_____

Age:_____ Date of Birth:_____ Social Security Number:_____

Sex: Male Female # of Children:_____ Circle One: Married Single Widowed Divorced

Occupation:_____ Employer:_____

Spouse: _____ Spouse's Employer: _____

Driver's License #:_____ State:_____ How were you referred to our office?_____

In Case of Emergency, please contact (include phone):_____

Please describe your condition(s) beginning with the most severe:

1._____ 3._____ 5._____

2._____ 4._____ 6._____

When did this/these conditions begin?_____ Is the condition getting: better worse same

What is the cause of your condition(s)?_____

What makes the condition feel better?_____ worse:_____

Have you seen any other physician for this condition? (please list name and dates)

_____

Have you ever been treated by another chiropractor? (if yes, who/when/same condition?)

Have you ever had similar symptoms to present condition?_____

Are you currently treating with any other physician? (if yes, please explain)

Please list your family physician, location (city & state) and medications you are currently taking:

Please list your complete surgical history (give dates & type of surgery):

Have you ever been involved in an automobile accident? (if YES, give dates & explain)

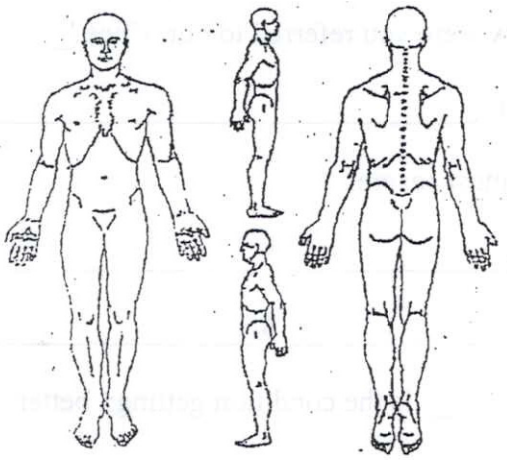
Name of person responsible for payment:

Would you like us to file insurance for you? YES NO Have you met your deductible? YES NO

Name of Insurance Company (if applicable):

If you are experiencing any of the following Conditions, please indicate on the diagram below:

A=ACHE B=BURNING N=NUMBNESS
P=PAIN S=STABBING O=OTHER



___1. HEADACHES
___2. DIZZINESS
___3. NECK PAIN
___4. NECK STIFFNESS
___5. UPPER BACK PAIN
___6. SHOULDER PAIN
___7. ARM OR HAND PAIN
___8. NUMBNESS OR TINGLING
___9. MID BACK PAIN
___10. LOW BACK PAIN
___11. HIP OR BUTTUCK PAIN
___12. LEG OR FOOT PAIN
___13. EAR NOISES
___14. SINUS INFECTION
___15. VISION PROBLEMS
___16. ALLERGIES
___17. CHEST PAIN
___18. DIFFICULT BREATHING
___19. FREQUENT URINATION
___20. PROSTATE PROBLEMS
___21. ARTHRITIS
___22. BURSITIS
___23. STROKE

I hereby authorize Sparks Chiropractic to examine me, including x-rays, if indicated by my exam, and to release my record to anyone I designate. I further authorize treatments deemed necessary by the findings, and wish all my chiropractic records to be held in strict secret confidence and not to be given to anyone without my written consent. I authorize payment directly to the doctor from my insurance company and I clearly understand that I am totally responsible for payment should my insurance company deny payment, or make payment directly to me. First day's fees are due and payable at the time of service.

BY SIGNING YOUR NAME BELOW, YOU CERTIFY THE ACCURACY OF YOUR MEDICAL AND/OR ACCIDENT HISTORY AND FURTHER CERTIFY THAT YOU PRESENT TO SPARKS CHIROPRACTIC OFFICE FOR EVALUATION AND TREATMENT OF A HEALTH RELATED CONDITION AND FOR NO OTHER PURPOSE.

Signature of patient, or guardian authorizing care

Date