



**SEA CLIFF
CHIROPRACTIC**
Dr. Russell Charno

NEW PATIENT INFORMATION

Name _____ **Date** _____

Address _____ **City** _____

State _____ **Zip** _____

Date of Birth _____ **Sex:** Male Female

Height _____ **Weight** _____

Social Security# _____

Phone (Home) _____ **Phone (Cell)** _____

Email _____

Occupation/ Employer _____ **Phone (Work)** _____

Insurance Company _____

Policy # _____ **Group #** _____

Group Name _____

Insured's Name _____ **Insured's Date of Birth** _____

Insured's ID. # or S.S. # _____

Emergency Contact _____ **Relationship** _____

Phone _____

How did you hear about our office? _____

Primary Care Physician's Name _____

City _____

It is our intention to communicate with your family doctor to coordinate the care provided in this office. This is in an effort to maintain the highest quality of care for you and your family. Please check one of the boxes below to indicate your preference.

- You are welcome to communicate with my primary care provider
- I would prefer that you do not communicate with my primary care provider unless medically necessary.



Sea Cliff Chiropractic

INITIAL EVALUATION

What brings you into our office? _____

Do you feel that your condition is: Improving Staying the Same Getting Worse

Have you lost time from work: Yes No

Can you perform physical work activities: Yes No

If no, because of: Pain Stress Weakness

Can you go to sleep without problems: Yes No

Does your condition wake you up at night: Yes No

Did you have sleep problems before: Yes No

Activities of Daily Living

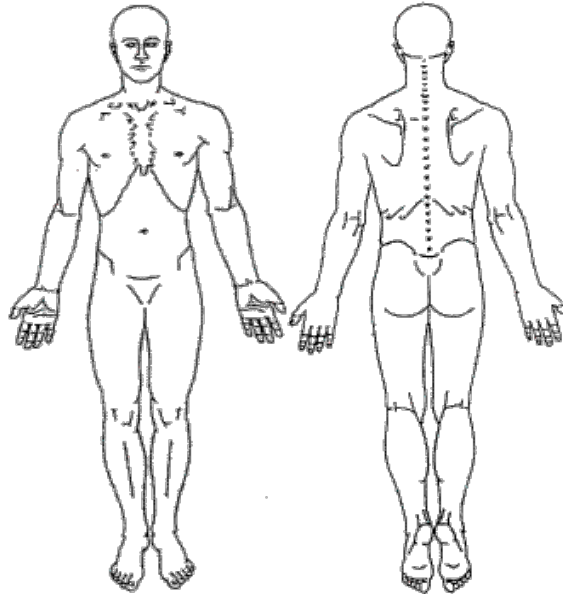
(Please select all activities with which you are currently experiencing problems)

- | | | | |
|--|--|--|---------------------------------------|
| <input type="checkbox"/> Seeing | <input type="checkbox"/> Tasting | <input type="checkbox"/> Smelling | <input type="checkbox"/> Eating |
| <input type="checkbox"/> Hearing | <input type="checkbox"/> Bathing | <input type="checkbox"/> Grooming | <input type="checkbox"/> Dressing |
| <input type="checkbox"/> Reading | <input type="checkbox"/> Typing | <input type="checkbox"/> Writing | <input type="checkbox"/> Grasping |
| <input type="checkbox"/> Holding | <input type="checkbox"/> Pinching | <input type="checkbox"/> Standing | <input type="checkbox"/> Leaning |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Stooping | <input type="checkbox"/> Squatting | <input type="checkbox"/> Climbing |
| <input type="checkbox"/> Kneeling | <input type="checkbox"/> Bending | <input type="checkbox"/> Twisting | <input type="checkbox"/> Carrying |
| <input type="checkbox"/> Lifting | <input type="checkbox"/> Pushing | <input type="checkbox"/> Pulling | <input type="checkbox"/> Reaching |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Driving | <input type="checkbox"/> Riding in Car | <input type="checkbox"/> Air Travel |
| <input type="checkbox"/> Sports | <input type="checkbox"/> Exercising | <input type="checkbox"/> Loss of Sex Drive | |
| <input type="checkbox"/> Reclining | <input type="checkbox"/> Restful Sleep | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Using Toilet |
| <input type="checkbox"/> Loss of Concentration | <input type="checkbox"/> Nervous | <input type="checkbox"/> Irritable | |
| <input type="checkbox"/> Change in Personality | <input type="checkbox"/> Tactile Feeling | | |

Other _____

COMPLAINT

Please place an X on the part of your body where you are experiencing pain or discomfort.



Please grade pain by circling a number from 0-10 (10 being the highest) 1 2 3 4 5 6 7 8 9 10

- The complaint came on:** Gradually Immediately
- Is getting:** Improving Staying the Same Getting Worse
- Intensity of this complaint is:** Minimal Moderate Slight Severe
- Frequency is:** Intermittent Occasional Frequent Constant
- The pain is:** Dull Sharp Aching Shooting
 Spasm Throbbing Burning Tingling
- The Pain is located:** Right Side Left Side Both Sides

Factors Affecting this Complaint:

(Select All that Apply)

Morning	<input type="checkbox"/> Brings On	<input type="checkbox"/> Aggravates	<input type="checkbox"/> Relieves
Afternoon	<input type="checkbox"/> Brings On	<input type="checkbox"/> Aggravates	<input type="checkbox"/> Relieves
Cold	<input type="checkbox"/> Brings On	<input type="checkbox"/> Aggravates	<input type="checkbox"/> Relieves
Heat	<input type="checkbox"/> Brings On	<input type="checkbox"/> Aggravates	<input type="checkbox"/> Relieves
Medication	<input type="checkbox"/> Brings On	<input type="checkbox"/> Aggravates	<input type="checkbox"/> Relieves
Resting	<input type="checkbox"/> Brings On	<input type="checkbox"/> Aggravates	<input type="checkbox"/> Relieves
Straining	<input type="checkbox"/> Brings On	<input type="checkbox"/> Aggravates	<input type="checkbox"/> Relieves
Standing	<input type="checkbox"/> Brings On	<input type="checkbox"/> Aggravates	<input type="checkbox"/> Relieves
Sitting	<input type="checkbox"/> Brings On	<input type="checkbox"/> Aggravates	<input type="checkbox"/> Relieves
Lying Down	<input type="checkbox"/> Brings On	<input type="checkbox"/> Aggravates	<input type="checkbox"/> Relieves
Bending Forward	<input type="checkbox"/> Brings On	<input type="checkbox"/> Aggravates	<input type="checkbox"/> Relieves
Bending Back	<input type="checkbox"/> Brings On	<input type="checkbox"/> Aggravates	<input type="checkbox"/> Relieves
Bending Left	<input type="checkbox"/> Brings On	<input type="checkbox"/> Aggravates	<input type="checkbox"/> Relieves
Bending Right	<input type="checkbox"/> Brings On	<input type="checkbox"/> Aggravates	<input type="checkbox"/> Relieves
Twisting Left	<input type="checkbox"/> Brings On	<input type="checkbox"/> Aggravates	<input type="checkbox"/> Relieves
Twisting Right	<input type="checkbox"/> Brings On	<input type="checkbox"/> Aggravates	<input type="checkbox"/> Relieves
Lifting	<input type="checkbox"/> Brings On	<input type="checkbox"/> Aggravates	<input type="checkbox"/> Relieves
Coughing	<input type="checkbox"/> Brings On	<input type="checkbox"/> Aggravates	<input type="checkbox"/> Relieves
Sneezing	<input type="checkbox"/> Brings On	<input type="checkbox"/> Aggravates	<input type="checkbox"/> Relieves

Are there any other activities that affect your complaint?

PAST MEDICAL HISTORY

(Check all that apply)

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Angina |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Aortic Aneurysm | <input type="checkbox"/> Arm pain | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Bladder Disease | <input type="checkbox"/> Breast Lumps | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Cardiovascular Disease |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Constipation | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Chronic Sinusitis |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Depression | <input type="checkbox"/> Dermatitis | <input type="checkbox"/> Difficulty Swallowing |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Fainting | <input type="checkbox"/> Frequent Urination |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Gout | <input type="checkbox"/> Headache | <input type="checkbox"/> Heart attack |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> High PSA | <input type="checkbox"/> High Triglyceride | <input type="checkbox"/> Hypertension | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Irritable Colon | <input type="checkbox"/> Jaw Pain |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Loss of Appetite | <input type="checkbox"/> Loss of Bladder Control | <input type="checkbox"/> Irregular Menstrual Flow |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Mental Disease | <input type="checkbox"/> Liver/Gallbladder |
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Pain in Foot/Ankle |
| <input type="checkbox"/> Leg Pain | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> PMS | <input type="checkbox"/> Painful Urination |
| <input type="checkbox"/> Prostate | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Swollen Joints | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Tinnitus | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Tumor | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Weight Loss/Gain | <input type="checkbox"/> Visual Disturbances |

Other _____

Is there anything you would like to add more detail to? _____

FAMILY HISTORY
(Check all that apply)

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Angina | <input type="checkbox"/> Aortic Aneurysm | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Bladder Disease | <input type="checkbox"/> Breast Lumps | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Convulsions | <input type="checkbox"/> COPD | <input type="checkbox"/> Cardiovascular Disease |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> High PSA | <input type="checkbox"/> High Triglyceride | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Irritable Colon | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Prostate | <input type="checkbox"/> Stroke | <input type="checkbox"/> Liver/Gallbladder |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Tumor | <input type="checkbox"/> Ulcer | |

If so, who? (ie. Father, Sister, Maternal Grandmother)

Other _____

Is there anything you would like to add more detail to? _____

SURGICAL HISTORY
(Check all that apply)

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> ACL Knee | <input type="checkbox"/> Adenoid | <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Abdomenoplasty |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Bunion | <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Carotid Artery |
| <input type="checkbox"/> Cataract | <input type="checkbox"/> Cervical | <input type="checkbox"/> Cosmetic Breast | <input type="checkbox"/> C-Section |
| <input type="checkbox"/> Facelift | <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Gastric Bypass | <input type="checkbox"/> Heart Bypass |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Hemorrhoid | <input type="checkbox"/> Hernia Repair | <input type="checkbox"/> Hip Replacement |
| <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Knee Arthroscopy | <input type="checkbox"/> Knee Replacement | <input type="checkbox"/> Knee Surgery |
| <input type="checkbox"/> Lasik | <input type="checkbox"/> Liposuction | <input type="checkbox"/> Lumbar Spine | <input type="checkbox"/> Mastectomy |
| <input type="checkbox"/> Prostate | <input type="checkbox"/> Rotator Cuff | <input type="checkbox"/> TMJ | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Vasectomy | <input type="checkbox"/> Adenoid | | |

Other _____

Is there anything you would like to add more detail to? _____

MEDICATIONS

(Please select all medications that you are currently taking)

- | | | | |
|--------------------------------------|--|--------------------------------------|---|
| <input type="checkbox"/> Advil | <input type="checkbox"/> Allergy | <input type="checkbox"/> Ambien | <input type="checkbox"/> Analgesics |
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Atenolol | <input type="checkbox"/> Antiinflammatories |
| <input type="checkbox"/> Ativan | <input type="checkbox"/> Chelation | <input type="checkbox"/> Clonzaepam | <input type="checkbox"/> Cumadin |
| <input type="checkbox"/> Cymbalta | <input type="checkbox"/> Diabetes Meds | <input type="checkbox"/> Flexeril | <input type="checkbox"/> Glucophage/Metformin |
| <input type="checkbox"/> Ibuprofen | <input type="checkbox"/> Lexapro | <input type="checkbox"/> Lipotor | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Lorpresssor | <input type="checkbox"/> Lovenox | <input type="checkbox"/> Lunesta | <input type="checkbox"/> Metaprolol |
| <input type="checkbox"/> Mevacor | <input type="checkbox"/> Monopril | <input type="checkbox"/> Motrin | <input type="checkbox"/> Muscle Relaxers |
| <input type="checkbox"/> Nexium | <input type="checkbox"/> Pain Medication | <input type="checkbox"/> Pepcid | <input type="checkbox"/> Plavix |
| <input type="checkbox"/> Prevacid | <input type="checkbox"/> Ritalin | <input type="checkbox"/> Skelaxin | <input type="checkbox"/> Soma |
| <input type="checkbox"/> Synthroid | <input type="checkbox"/> Testosterone | <input type="checkbox"/> Tylenol | <input type="checkbox"/> Valium |
| <input type="checkbox"/> Verapamil | <input type="checkbox"/> Vicodin | <input type="checkbox"/> Wellbrutrin | <input type="checkbox"/> Zocor |

Other _____

Please list all nutritional supplements that you take: _____

ALLERGIES

Please list any allergies that you may have:

SOCIAL HISTORY

- Married Single Widowed Divorced Separated

Do you have any children? If so, how many? _____

Do you use:

- Alcohol #/Week _____ Tobacco #/Week _____ Caffeine#/Week _____

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including a comprehensive exam, diagnostic x-rays, physical therapy techniques, on me (or on the patient named below for which I am legally responsible) by the licensed doctors of chiropractic at this office.

I understand that, as with any health procedure, there are certain conditions that may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, dislocations, muscle strain, costovertebral strains and separations. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. This is a very rare occurrence (a one in three million chance). We screen our patients for indications that they are candidates for chiropractic adjustments to the best of our ability. I do not expect the doctor to be able to anticipate all risk and complications during the course of the procedure(s) that the doctor feels at the time, based upon the facts then known, are in the best interest.

I have had an opportunity to discuss with the doctor the nature, purpose, and risk of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having being informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Name (Please Print)

Patient Signature

Date

Signature of patient's representative (if minor)

Date



SEA CLIFF CHIROPRACTIC

91 Roslyn Ave., Sea Cliff, NY 11570 • Tel (516) 316-4589 • Fax (516) 706-0863
drc@seacliffchiropractic.com • www.seacliffchiropractic.com

Dr. Russell Charno

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU
MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO
THIS INFORMATION.**

- By the law, consent is not required to discuss your medical treatment with your other doctors or health care providers.
- Additionally, none is needed in the course of carrying out health care operations, such as quality assessment, or in communication with your insurance carrier for payment related issues, or for incidental uses, such as announcing a name in a waiting room or use of sign-in sheets.
- Specific authorization is required to disclose protected information in a non-routine circumstance, such as to your employer or for use in marketing a product to you.
- Medical information about you may be released for research and public health uses, as long as you are not individually identified.
- You are guaranteed access to review your medical record, and you may amend the record if you believe it to be incomplete or inaccurate.
- You have the right to review when and to whom your information was released.
- You may suggest additional restrictions with regard to certain uses and disclosures, if you wish.
- Portions of this notice may be modified, as long as you are notified.
- Should you believe that your privacy rights have been compromised, you may report the violation, without penalty to you, to this office or to the Secretary of Health.
- The law required that you acknowledge receipt of this notice.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I have hereby received a copy of the Notice of Privacy Practices for Sea Cliff Chiropractic.

Name of Patient _____

Signature of Patient _____

Date _____

Signature of Patient Representative (required if the patient is a minor or an adult who is unable to sign this form) _____

Relationship of Patient Representative to Patient _____