DR. RUSSELL CHARNO
Chiropractic & Functional Rehabilitation

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.

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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)

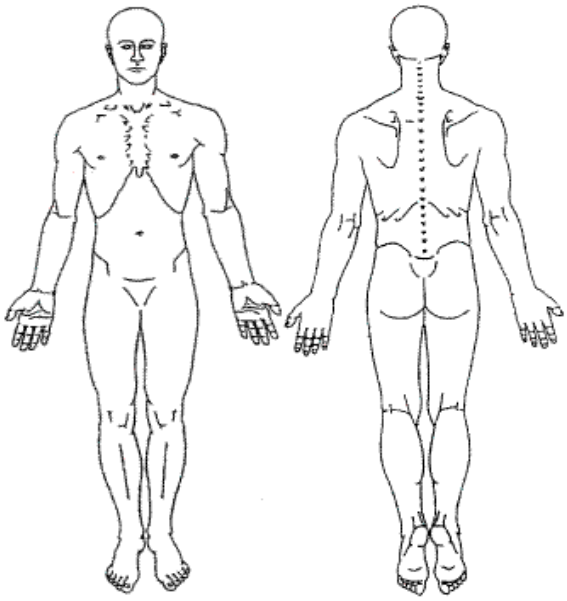
☐ Seeing	☐ Tasting	☐ Smelling	☐ Eating
☐ Hearing	☐ Bathing	☐ Grooming	☐ Dressing
☐ Reading	☐Typing	☐ Writing	☐ Grasping
☐ Holding	☐ Pinching	☐ Standing	☐ Leaning
☐ Walking	☐ Stooping	☐ Squatting	☐ Climbing
☐ Kneeling	☐ Bending	☐ Twisting	☐ Carrying
☐ Lifting	☐ Pushing	☐ Pulling	☐ Reaching
☐ Sitting	☐ Driving	☐ Riding in car	☐ Air Travel
☐ Sports	☐ Exercising	☐ Loss of Sexual Drive	☐ Irritable
☐ Reclining	☐ Restful Sleeping	☐ Nervous	☐ Loss of Concentration
☐ Insomnia	☐ Using the Toilet	☐ Tactile Feeling	☐ Change in Personality

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	☐ Brings On	☐ Aggravates	☐ Relieves
Afternoon	☐ Brings On	☐ Aggravates	☐ Relieves
Cold	☐ Brings On	☐ Aggravates	☐ Relieves
Heat	☐ Brings On	☐ Aggravates	☐ Relieves
Medication	☐ Brings On	☐ Aggravates	☐ Relieves
Resting	☐ Brings On	☐ Aggravates	☐ Relieves
Straining	☐ Brings On	☐ Aggravates	☐ Relieves
Standing	☐ Brings On	☐ Aggravates	☐ Relieves
Sitting	☐ Brings On	☐ Aggravates	☐ Relieves
Lying Down	☐ Brings On	☐ Aggravates	☐ Relieves
Bending Forward	☐ Brings On	☐ Aggravates	☐ Relieves
Bending Back	☐ Brings On	☐ Aggravates	☐ Relieves
Bending Left	☐ Brings On	☐ Aggravates	☐ Relieves
Bending Right	☐ Brings On	☐ Aggravates	☐ Relieves
Twisting Left	☐ Brings On	☐ Aggravates	☐ Relieves
Twisting Right	☐ Brings On	☐ Aggravates	☐ Relieves
Lifting	☐ Brings On	☐ Aggravates	☐ Relieves
Coughing	☐ Brings On	☐ Aggravates	☐ Relieves
Sneezing	☐ Brings On	☐ Aggravates	☐ Relieves

Are there any other activities that affect your complaint?

_____

_____

_____

PAST MEDICAL HISTORY
(Check all that apply)

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

Other_____

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

_____

_____

FAMILY HISTORY
(Check all that apply)

☐ Anxiety	☐ Angina	☐ Aortic Aneurysm	☐ Arthritis
☐ Asthma	☐ Bladder Disease	☐ Breast Lumps	☐ Cancer
☐ Colitis	☐ Convulsions	☐ COPD	☐ Cardiovascular Disease
☐ Depression	☐ Diabetes	☐ Epilepsy	☐ Gout
☐ Heart attack	☐ Heart disease	☐ Heartburn	☐ Hepatitis
☐ High PSA	☐ High Triglyceride	☐ High Blood Pressure	☐ High Cholesterol
☐ Irritable Colon	☐ Kidney Disease	☐ Low Back Pain	☐ Lung Disease
☐ Osteoarthritis	☐ Prostate	☐ Stroke	☐ Liver/Gallbladder
☐ Thyroid Disease	☐ Tumor	☐ 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)

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

Other_____

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

_____

MEDICATIONS

(Please select all medications that you are currently taking)

☐ Advil	☐ Allergy	☐ Ambien	☐ Analgesics
☐ Antibiotics	☐ Aspirin	☐ Atenolol	☐ Antiinflammatories
☐ Ativan	☐ Chelation	☐ Clonzaepam	☐ Cumadin
☐ Cymbalta	☐ Diabetes Meds	☐ Flexeril	☐ Glucophage/Metformin
☐ Ibuprofen	☐ Lexapro	☐ Lipotor	☐ High Blood Pressure
☐ Lorpressor	☐ Lovenox	☐ Lunesta	☐ Metaprolol
☐ Mevacor	☐ Monopril	☐ Motrin	☐ Muscle Relaxers
☐ Nexium	☐ Pain Medication	☐ Pepcid	☐ Plavix
☐ Prevacid	☐ Ritalin	☐ Skelaxin	☐ Soma
☐ Synthroid	☐ Testosterone	☐ Tylenol	☐ Valium
☐ Verapamil	☐ Vicodin	☐ Wellbrutrin	☐ 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_____

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Izlind Integrative Wellness
6369 Mill Street, Suite 101 Rhinebeck NY 12575
(516) 316-4589 / drcharno@gmail.com / www.drcharno.com

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.

ACKNOLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I have hereby received a copy of the Notice of Privacy Practices for Dr. Russell Charno

_____
Patient Name (Please Print)

_____ _____
Patient Signature **Date**

_____ _____
Signature of patient's representative (if minor) **Date**

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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**