RUSSO FAMILY CHIROPRACTIC

Dr. Leonard M. Russo

397 US 46 West
Fairfield, NJ 07004

259 Washington Ave
Nutley, NJ 07110

(973) 227-3338

Please print neatly and complete all questions.

Patient Name:		**Today's Date:**	
Date of Birth:		**Social Security #:**	
Address	**City**	**State**	**Zip**
Email:			
Age:	**Height:** **Weight:**	**Pain scale**	
Phone:		**Social Security #:**	
Marital Status:	**First Date of Symptoms:**	**Insurance Policyholder's Name and Relationship:**	
Policyholder's SS#: (if different from patient)		**Occupation:**	
Employer:			□ **Full Time** □ **Part Time**
Employer Address		**Work Phone:**	
How did you hear about our office?			
Spouse/Emergency Contact		**Relationship to Patient**	
Address	**Home Phone**	**Work Phone**	
Primary MD Name		**Phone**	
Address			

Please inform the office if you have a secondary health insurance coverage.

□ Headaches	□ Neck Pain	□ Arm Pain	□ Arm/Hand Numbness	□ Mid Back Pain	□ Chest Pain	□ Low Back Pain
□ Buttock Pain	□ Hip Pain	□ Leg Pain	□ Leg/Foot Numbness	□ Other:		

Onset: (How did your pain start?): □ Unknown □ Woke up with it □ Bending/Twisting □ Slip/Fall □ Accident

Explain:

Past Medical History (Please check each if you have had the following problems)

□ Angina	□ Angioplasty	□ Arrhythmia	□ Arthritis	□ Asthma	□ Bypass
□ Cancer – Where?_____			□ Diabetes	□ Dialysis	□ Diverticulosis
□ Emphysema	□ Hypertension	□ Headaches	□ Heart Attack	□ Heart Disease	□ Heart Failure
□ Hemophilia	□ Hemorrhoids	□ High Cholesterol	□ Impotence	□ Kidney Stone	□ Kidney Problem
□ Leg Swelling	□ Liver Problem	□ Murmur	□ Obesity	□ Pacemaker	□ Pass Out
□ Pneumonia	□ Reflux	□ Rheumatic Fever	□ Rheumatoid	□ Sleep Apnea	□ Stroke
□ Surgeries:_____				□ Thyroid	□ Tuberculosis
□ Ulcer	□ Varicose Veins	□ Other:_____			

Family Medical History

Please check each if any family member (mother, father or siblings) has had any of the following problems

□ Angina	□ Angioplasty	□ Arrhythmia	□ Arthritis	□ Asthma	□ Bypass
□ Cancer – Where?_____			□ Diabetes	□ Dialysis	□ Diverticulosis
□ Emphysema	□ Hypertension	□ Headaches	□ Heart Attack	□ Heart Disease	□ Heart Failure
□ Hemophilia	□ Hemorrhoids	□ High Cholesterol	□ Impotence	□ Kidney Stone	□ Kidney Problem
□ Leg Swelling	□ Liver Problem	□ Murmur	□ Obesity	□ Pacemaker	□ Pass Out
□ Pneumonia	□ Reflux	□ Rheumatic Fever	□ Rheumatoid	□ Sleep Apnea	□ Stroke
□ Surgeries:_____				□ Thyroid	□ Tuberculosis
□ Ulcer	□ Varicose Veins	□ Other:_____			

Current Medications/Vitamins

Name of Medication/Vitamin	Strength	Dosage

List of Known Allergies

□ **Tobacco** □ Type:_____ □ Year Begun:___ □ Still Smoking □ Year Quit: _____ □ Packs Per Day:__	□ **Alcohol** □ Type:_____ □ How Often:_____ □ How Much:_____ □ How Many Years:_____	□ **Exercise** □ None □ Light □ Moderate □ Heavy

Patient Medical History

Please check each if any family member (mother, father or siblings) has had any of the following problems

General:	□ Weight Gain □ Surgeries	□ Weight Loss □ Other:_____	□ Fever	□ Hair Loss
Eyes:	□ Eye Strain	□ Glasses	□ Contact Lenses	□ Sensitivity to Light

Ear, Nose Throat:	□ Ringing in Ears □ Hearing Loss □ Discharge or Pain □ Dizziness □ Runny Nose □ Sinusitis □ Difficulty Breathing Through Nose □ Painful Teeth, Gums, or Palate □ Growths in Mouth □ Pain or Difficulty Swallowing □ Hoarseness
Cardiovascular:	□ Palpitations □ Chest Pain □ Fainting □ Dizziness □ Varicose Veins □ Difficulty Climbing Stairs □ Pain in the Legs □ Cold Feet/Hands □ Shortness of Breath
Respiratory:	□ Shortness of Breath While Walking □ Cough (With or Without Phlegm) □ Asthma/Wheezing □ Spit Up Blood □ Other:_____
Gastrointestinal:	□ Abdominal Pain □ Nausea □ Vomiting □ Diarrhea □ Hemorrhoids □ Change in Shape or Color of Stool
Gastrointestinal:	□ Discharge □ Pain □ Frequent Urination □ Pain With Urination
Musculoskeletal:	□ Weakness □ Back Pain □ Neck Pain □ Leg Pain □ Arm Pain □ Shoulder Pain □ Numbness □ Headaches □ Other:_____
Skin:	□ Jaundice □ Dry Skin □ Pigment Change □ Growths □ Moles That Have Changed Color, Shape, or Bleed
Neurological:	□ Tremors □ Weakness □ Numbness □ Memory Loss □ Confusion □ Other:_____

AUTHORIZATION FOR OBTAINING HEALTHCARE RECORDS

I,_____, authorize Dr. Leonard M. Russo, and Russo
(Patient Name)
Family Chiropractic, and 186 Fairfield Rd., LLC, to obtain the protected healthcare information from: _____.
(Individual Releasing Information)

Information Requested:

_____

_____ _____
Patient's Signature Witness

_____
Date