  
 Jeanette I. Chomic, D.C.   
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**Mini Case History**

**Patient Information**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Nickname/Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender: M F Age: \_\_\_\_\_\_ DOB: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ SS #: \_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Text: Yes\_\_\_\_\_ No \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: 🌕 S 🌕 M 🌕 D 🌕 W Work Status: 🌕 Full Time 🌕 Part Time 🌕 Retired 🌕 Student

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Insurance**

Do you have health insurance? 🌕 Y 🌕 N If yes, please fill out the information below:

Is this visit going to be billed to your Auto insurance or Workman’s Comp? 🌕 Y 🌕 N

**Primary:** Name of Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured’s DOB: \_\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary:** Name of Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured’s DOB: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\* Please give a copy of your insurance card(s) to the Front Desk. \*\***

\*By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or other communications. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I consent to the receiving of multiple messages per day from the automated outreach and messaging system, when necessary.

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May we e-mail you? 🌕 Y 🌕 N

Would you like appointment reminders texted to your cell phone? 🌕 Y 🌕N

May we leave voicemail on Home/Cell Phone: 🌕 Y 🌕 N \*\*Permissions can be changed at any time upon request\*

**Protected health information may be disclosed to:**

**x\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Health History**

Have you had any operations since your last visit to our office? Yes\_\_\_\_\_\_ No\_\_\_\_\_\_ If yes, please list \_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pregnant: Yes \_\_\_\_\_ No \_\_\_\_\_ If Yes, Due Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently taking any medications: Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please provide a detailed explanation of SPECIFIC AREAS IN WHICH YOU ARE EXPERIENCING PAIN and/or the purpose of today’s visit. Please describe frequency, intensity, and how long you have been experiencing pain. If you have had any FALLS, INJURIES, OR EXACERBATIONS, please provide the date and circumstances of the injury.

**Please check all that apply since your last visit:**

\_\_\_\_\_ Falls \_\_\_\_\_ Auto Accident \_\_\_\_\_ New Job \_\_\_\_\_ Traumas

\_\_\_\_\_ New Injury \_\_\_\_\_ Playing New Sport \_\_\_\_\_ Recent or Major Illness

|  |  |  |  |
| --- | --- | --- | --- |
| **Region** | **Neck (cervical)** | **Mid back(thoracic)** | **Low Back (lumbar)** |
| **Pain Scale** | 0 1 2 3 4 5 6 7 8 9 10 | 0 1 2 3 4 5 6 7 8 9 10 | 0 1 2 3 4 5 6 7 8 9 10 |
| **Frequency** | Constant On/Off Sometimes | Constant On/Off Sometimes | Constant On/Off Sometimes |

When did symptoms begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ What initiated symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has it worsened over time: 🌕 Y 🌕 N 🌕 Same 🌕 Better 🌕 Worse

Please Check all that apply:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Light | Moderate | Heavy | None |
| Alcohol Consumption |  |  |  |  |
| Coffee, Tea |  |  |  |  |
| Soda, Diet Soda |  |  |  |  |
| Tobacco |  |  |  |  |
| Recreational Drugs |  |  |  |  |
| Stress Level |  |  |  |  |

***\*\*\*Please notify the front desk if you have experienced any injuries work, auto or personal injury related so we may have you fill out the proper paperwork.\*\*\****

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

**Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date**