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**New Patient Information-Child 3-10**

**Welcome!** Today’s Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_

**Emergency Contact**

Emergency Contact Person #1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Person #2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/Guardian Information**

Mother or Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS #: \_\_\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_

Home Phone (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father or Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS #: \_\_\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_

Home Phone (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Information**

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

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

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**\*\*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.**

May we e-mail you? 🌕 Y 🌕 N

Would you like appointment reminders texted to your cell phone? 🌕 Y 🌕 N **\*If yes, which number**? \_\_\_\_\_\_\_\_\_\_\_\_

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

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

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

Printed Name

\*\*\*We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

**Insurance Information:**

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

**Primary:** Name of Subscriber: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

 Name of Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary:** Name of Subscriber: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

 Name of Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Tertiary:** Name of Subscriber: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_

Name of Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🌕 Internet 🌕 Yellow Pages

🌕 Doctor, Name of Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🌕 Friend/ Family 🌕 Other

**Health Information:**

Health Concerns: (please List in priority order and use back for additional space)

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**Symptoms/Complaints: (relating to primary complaints)**

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

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

Have your child previously been treated for this condition by another provider? 🌕 Y 🌕 N

If yes, by whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Treatment received:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any reactions to pervious treatment? 🌕 Y 🌕 N Describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

How long does it last? 🌕 All Day 🌕 Hours 🌕 Minutes 🌕 Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the problem worse during a certain time of day? 🌕 Morning 🌕 Afternoon 🌕 Evening 🌕 Night 🌕 Other

Is this condition interfering with: 🌕 School 🌕 Sleep 🌕 Daily Routine 🌕 Recreation 🌕 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe the symptoms (check all that apply): 🌕 Dull 🌕 Achy 🌕 Pain 🌕 Sharp 🌕 Stabbing 🌕 Numbness

🌕 Tingling 🌕 Burning 🌕 Shooting 🌕 Stiffness 🌕 Tightness 🌕 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes the problem worse? 🌕 Standing 🌕 Sitting 🌕 Walking 🌕 Bending 🌕 Lifting 🌕 Twisting 🌕 Changing

positions 🌕 Movement 🌕 Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you found things that relieve symptoms? 🌕 Y 🌕 N **If yes**, describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have other conditions or symptoms that may be related to current symptoms? 🌕 Y 🌕 N

If yes, what?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Treatment: What type of treatment are you looking to receive?

🌕 Symptom Relief 🌕 Correctional Care 🌕 Total Wellness Care 🌕 All 3 choices

**Health History:**

Have you had any major childhood traumas or accidents? 🌕 Y 🌕 N If yes, describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Have you had any surgeries or procedures? 🌕 Y 🌕 N If yes, describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Have you had any significant childhood illnesses? 🌕 Y 🌕 N If yes, describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Any childhood antibiotic use? 🌕 Y 🌕 N

Please list any medications that your child is currently taking, including over the counter medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any known allergies to medication? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any food intolerances or allergies? 🌕 Y 🌕 N If yes, list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How is digestion? Regular bowel movements? 🌕 Y 🌕 N How many per day? \_\_\_\_\_\_\_\_\_\_\_\_

How is sleep? How many hours at a time at night? \_\_\_\_\_\_\_\_\_\_\_

How many hours per day of screen time? \_\_\_\_\_\_\_\_\_\_

Are you involved in any sports or activities? ○ Y ○ N If so, what sports:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you getting any physical activity? ○ Y ○ N If so, what and how much:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please mark all other applicable health related symptoms or conditions as they apply:

🌕 Headache 🌕 Shoulder Pain 🌕 Tingling in Hands 🌕 Fainting

🌕 Facial Pain 🌕 Persistent Cough 🌕 Clammy Hands 🌕 Convulsions

🌕 Blurred Vision 🌕 Chest Pressure 🌕 Low Back Pain 🌕 Irritability

🌕 Dizziness 🌕 Slow Heart Rate 🌕 Hip Pain 🌕 Impatience

🌕 Earache 🌕 Rapid Heart Rate 🌕 Knee Pain 🌕 Feel Loss of Control

🌕 Eye Pain 🌕 High Blood Pressure 🌕 Poor Circulation 🌕 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🌕 Forgetfulness 🌕 Low Blood Pressure 🌕 Swollen Joints \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🌕 Confusion 🌕 Abdominal Pain 🌕 Joint Stiffness

🌕 Sinusitis 🌕 Nausea/Vomiting 🌕 Swollen Ankles \*Additional (check all that apply)

🌕 Teeth Grinding 🌕 Poor Appetite 🌕 Ankle/Foot Pain 🌕 Seizures (Epilepsy)

🌕 Dry Mouth 🌕 Fullness of Bladder 🌕 Tingling in Feet 🌕 Transplant

🌕 Excessive Thirst 🌕 Urination Difficulty 🌕 Walking Problems 🌕 Surgically Implanted Device

🌕 Unpleasant Taste 🌕 Frequent Urination 🌕 Sore Muscles 🌕 Pacemaker

🌕 Neck Pain 🌕 Constipation 🌕 Weak Muscles

🌕 Sore Throat 🌕 Hemorrhoids 🌕 Paralysis

🌕 Lump in Throat 🌕 Elbow/Hand Pain 🌕 Shakiness

🌕 Swallowing Pain 🌕 Sweating

🌕 Unsteady Voice 🌕 Insomnia

**Family History:**

Identify conditions that your or any of your family members have now or in the past.

(G=Grandparents, M=Mother, F=Father, S=Sibling, X=Self)

\_\_\_\_\_ Allergies \_\_\_\_\_ Eczema \_\_\_\_\_ Headaches/Migraines \_\_\_\_\_ Pneumonia

\_\_\_\_\_ Alcoholism \_\_\_\_\_ Emphysema \_\_\_\_\_ HIV/AIDS \_\_\_\_\_ Stroke Ulcer(s)

\_\_\_\_\_ Anemia \_\_\_\_\_ Epilepsy \_\_\_\_\_ Miscarriage(s) \_\_\_\_\_ Tumor(s)

\_\_\_\_\_ Cancer \_\_\_\_\_ Gout \_\_\_\_\_ Overweight \_\_\_\_\_ Ulcer(s)

\_\_\_\_\_ Diabetes \_\_\_\_\_ Heart Disease \_\_\_\_\_ Pleurisy \_\_\_\_\_ Addiction

\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please Check all that apply:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Light | Moderate | Heavy | None |
| Physical Activity |  |  |  |  |
| Coffee, Tea |  |  |  |  |
| Soda, Diet Soda |  |  |  |  |
| Stress Level |  |  |  |  |