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**New Patient Information**

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

**Contact Information**

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

May we contact you at work? 🌕 Y 🌕 N If yes, Work Phone: (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Information**

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

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

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

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_\_\_\_ Marital Status: 🌕 S 🌕 M 🌕 D 🌕 W # of children: \_\_\_\_\_\_\_

Work Status: 🌕 Full Time 🌕 Part Time 🌕 Retired 🌕 Student 🌕 Other

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

**Spouse/Parent/Guardian Information**

Spouse, Parent or Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

If your spouse, parent or guardian is a patient in our office, please list them below:

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

**Emergency Contact**

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

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

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

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

**\*\*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

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:**

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: \_\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

Ins. Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

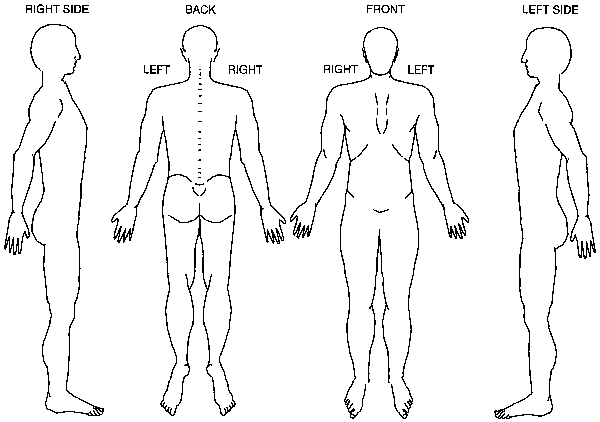
Ins. Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Ins. Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Information**

|  |  |  |  |
| --- | --- | --- | --- |
| **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 |



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

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

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

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

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

Have you had any reactions to previous 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 your: 🌕 Work 🌕 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 been involved in any accidents or traumas? 🌕 Y 🌕 N If yes, describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

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

Any recent or major illnesses? 🌕 Y 🌕 N If yes, describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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 🌕 Decreased Sex Drive 🌕 Shakiness

🌕 Swallowing Pain 🌕 Menstrual Irregularities 🌕 Sweating

🌕 Unsteady Voice 🌕 Elbow/Hand Pain 🌕 Insomnia

**Work & Social History:**

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🌕 Heavy Labor 🌕 Light Labor 🌕 Mostly Sitting 🌕 Mostly Standing

🌕 Walking/Moving 🌕 Driving List job activities:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Are you: 🌕 Left Handed 🌕 Right handed 🌕 Ambidextrous

Exercise: 🌕 None 🌕 Light 🌕 Moderate 🌕 Heavy Exercise Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency:\_\_\_\_\_\_\_\_\_\_\_\_

Hours of sleep per night:\_\_\_\_\_\_\_\_ Uninterrupted sleep? 🌕 Y 🌕 N Do you feel rested upon waking? 🌕 Y 🌕 N

How many meals per day do you eat? \_\_\_\_\_\_\_\_ How much water per day do you drink? \_\_\_\_\_\_\_\_\_\_\_\_\_

For women only: Are you currently pregnant? 🌕 Y 🌕 N Are you currently breast feeding? 🌕 Y 🌕 N

Please Check all that apply:

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

**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 list any current medications you are taking or give a list to the Front Desk:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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**\*\*\*Minor Consents:** If you are a parent/legal guardian filling out paperwork for a minor child, please ask our Front Desk about filling out Consent forms for your child to be seen without a parent/guardian present **OR** for another family member to bring your child to appointments.