Traub Chiropractic Care Center
N58 W39799 Hwy 16 P.O. Box 221
Oconomowoc, WI 53066
Telephone: (262) 567-4497 Fax: (262) 567-3716
www.traubchiropractic.com

Michael R. Traub, D.C.
Karen I. Gould, D.C.
Nathan J. Omick, D.C.

Patient Name: First _____ MI____ Last_____ Nickname _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home#:(____)_____ Cell#: (____) _____ S.S. #:_____

Date of Birth: _____ Age: _____ Marital Status: S M D W

Email:_____ Sex: Female or Male

Employers Name: _____ Work#: (___)_____

Physician Name: _____ Last X-ray Date: _____ MRI/CTSCAN: _____

Have you seen a chiropractor before? Y / N Name:_____

Specialists currently seeing or have seen and for what reason? _____

In event of emergency, contact: _____ Phone: _____

AREAS OF PAIN or SYMPTOMS:_____

When did the symptoms begin: _____ **Cause of injury:** _____

Is this a work related injury? Y / N If so, have you reported this to your employer? Y / N

Is this an Auto Accident? Y / N If so, did you report it to your auto carrier? Y / N

Patient History:

Office Use Only:

Ht: _____ Wt_____ Blood Pressure _____ Pulse_____

Please list all medications: _____

_____

List all Surgeries: _____

Hospitalizations:_____

Have you been diagnosed with (Y or N): High Blood Pressure? _____ Diabetes? _____

Major Illnesses, Accidents or Injuries: _____

Allergies: _____ Habits: Smoke Y/ N/ Ever? _____ Alcohol Y / N / Ever? ___

Exercise: Low Medium High

Family History: (diabetes, cancer, high blood pressure, heart disease, kidney disease, stroke, back problems)

Mother: _____ Paternal Grandparents:_____

Father: _____ Maternal Grandparents:_____

Brother: _____ Son: _____

Sister: _____ Daughter: _____

Patients/Gaurdian Signature: _____ Date:_____

Other Side

Circle: A = Always or S = Sometimes for each symptom (leave blank = do not have)

MUSCULOSKELETAL
A OR S Arthritis
A OR S Bursitis
A OR S Foot Problems
A OR S Low Back
A OR S Neck
A OR S Shoulder Pain
A OR S Elbow Pain
A OR S Wrist Pain
A OR S Arm Pain/Numbness
A OR S Leg Pain/Numbness
A OR S Hip Pain
A OR S Knee Pain
A OR S Foot/Ankle Pain
A OR S TMJ Problems

CARDIOVASCULAR
A OR S Chest Pain
A OR S Shortness of Breath
A OR S Pain Over Heart
A OR S Swollen Ankles
A OR S Poor Circulation
A OR S High Blood Pressure
A OR S Low Blood Pressure
A OR S Arteriosclerosis
A OR S Heart Disease
A OR S Heart Attacks
A OR S Heart Surgery
A OR S Strokes
A OR S Pacemaker

GENITOURINARY
A OR S Blood in Urine
A OR S Pain in Urination
A OR S Loss of Bladder Control
A OR S Prostate Trouble

GASTROINTESTINAL
A OR S Constipation
A OR S Diarrhea
A OR S Jaundice
A OR S Vomiting blood
A OR S Colitis
A OR S Colon Trouble
A OR S Hemorrhoids
A OR S Gallbladder Trouble
A OR S Hernia

ENDOCRINE
A OR S Intolerance to Cold
A OR S Intolerance to Heat
A OR S Enlarged Thyroid

CONSTITUTION
A OR S Fever
A OR S Vomiting
A OR S Dizziness
A OR S Weight
A OR S Night Sweats

INTEGUMENTARY & SKIN
A OR S Boils
A OR S Rash
A OR S Change in Moles
A OR S Eczema
A OR S Psoriasis

HEMATOLOGICAL/LYMPH
A OR S Nose Bleeds
A OR S Bruising
A OR S Swollen Glands
A OR S Sore Throat

IMMUNOLOGICAL/ALLERY
A OR S Sinus Trouble
A OR S Frequent Colds
A OR S Hay Fever
A OR S Wheezing

EYE, EAR, NOSE, & THROAT
A OR S Eye Pain
A OR S Double Vision
A OR S Change in Vision
A OR S Ear Pain
A OR S Loss of Hearing

RESPIRATORY
A OR S Difficulty Breathing
A OR S Cough
A OR S Lung Congestion
A OR S Spitting up Blood

WOMEN ONLY
A OR S Pain in Breast
A OR S Breast Lump
A OR S Irregular Cycle
A OR S Painful Menstruation
Y OR N No Cycle
Y OR N Menopause
Y OR N Hysterectomy
Y OR N Are You Pregnant
# of Children _____

CONDITIONS: **(Circle if had or have)**
Alcoholism
Anemia
Appendicitis
Cancer
Chicken Pox
Measles
Gout
Diabetes
Epilepsy
Pneumonia
Emphysema
Polio
Insomnia
Strain/Sprain
Broken Bones
Rheumatic Fever
Struck Unconscious
Multiple Sclerosis
Fibromyalgia
Asthma

Function Rating Index

In order to assess your condition, we must understand how much your neck and or back problems have affected your ability to manage everyday activities. For each item below, Please circle the number that most closely describes your condition right now.

Pain Intensity

0 = No pain
1 = Mild Pain
2 = Moderate Pain
3 = Severe pain
4 = Worst possible pain

Sleeping

0 = Perfect sleep
1 = Mildly disturbed sleep
2 = Moderately disturbed sleep
3 = Greatly disturbed sleep
4 = Totally disturbed sleep

Personal Care (washing, dressing, etc.)

0 = No pain; no restrictions
1 = Mild pain; no restrictions
2 = Moderate pain; need to go slowly
3 = Moderate pain; need some assistance
4 = Severe pain; need 100% assistance

Travel (driving, etc.)

0 = No pain on long trips
1 = Mild pain on long trips
2 = Moderate pain on long trips
3 = Moderate pain on short trips
4 = Severe pain on short trips

Work

0 = Can do usual work plus unlimited extra work
1 = Can do usual work; no extra work
2 = Can do 50% of usual work
3 = Can do 25% of usual work
4 = Cannot work

Lifting

0 = No pain with heavy weight
1 = Increased pain with heavy weight
2 = Increased pain with moderate weight
3 = Increased pain with light weight
4 = Increased pain with any weight

Walking

0 = No pain any distance
1 = Increased pain after 1 mile
2 = Increased pain after ½ mile
3 = Increased pain after ¼ mile
4 = Increased pain with all walking

Standing

0 = No pain after several hours
1 = Increased pain after several hours
2 = Increased pain after 1 hour
3 = Increased pain after ½ hour
4 = Increased pain with any standing

Frequency of Pain

0 = No pain
1 = Occasional pain; 25% of the day
2 = Intermittent pain; 50% of the day
3 = Frequent pain; 75% of the day
4 = Constant pain; 100% of the day

Recreation

0 = Can do all activities
1 = Can do most activities
2 = Can do some activities
3 = Can do a few activities
4 = Cannot do any activities

NAME _____ TOTAL SCORE_____

SIGNATURE_____ DATE:_____

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Pain Drawing

Name_____ Date_____

Please be sure to fill this out accurately. Mark the area on your body where you feel the described sensation(s). Use the appropriate key and mark the areas of radiating pain, and all the affected areas. You may draw in the face as well.

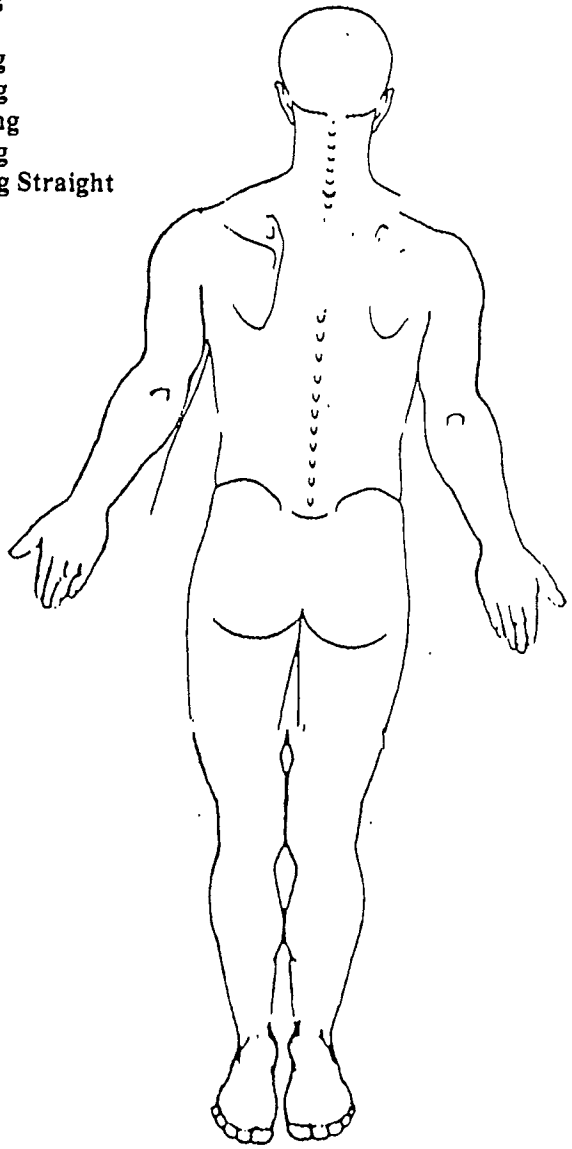
N = Numbness P = Pins & Needles B= Burning Pain S= Stabbing Pain A= Aching Pain

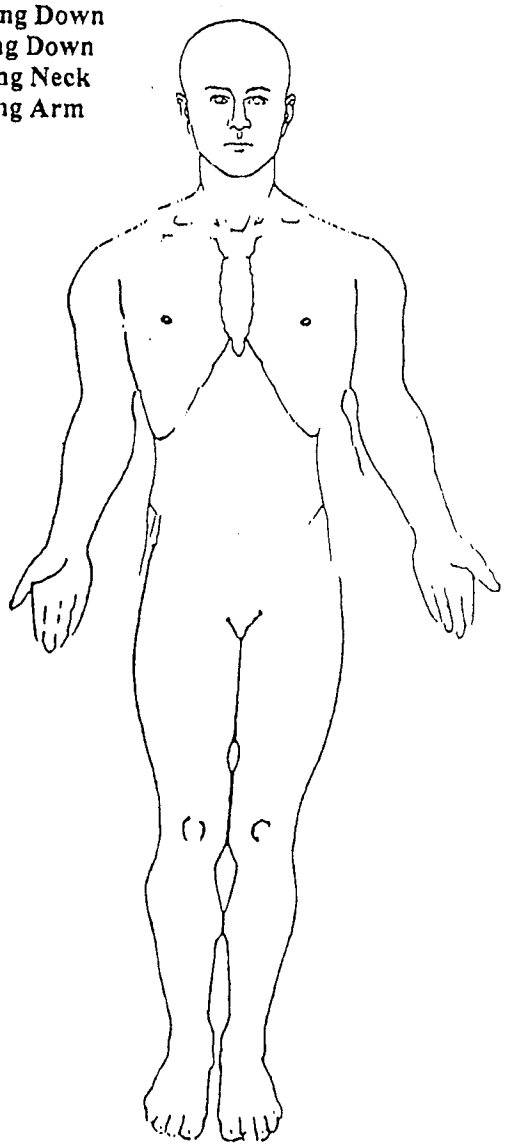
Low Back (√ below what makes it worse)

____ Sitting
____ Standing
____ Bending
____ Laying
____ Walking
____ Twisting
____ Coughing
____ Sneezing
____ Standing Straight
____ Driving

Neck (√ below what makes it worse)

____ Turning Head
____ Looking Up
____ Looking Down
____ Laying Down
____ Moving Neck
____ Raising Arm





ON PAIN SCALE OF 1-10, WITH 10 BEING WORST, RATE YOUR AREA OF PAIN. _____

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TRAUB CHIROPRACTIC CARE CENTER

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

The nature of Chiropractic Treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electrical muscle stimulation, therapeutic ultrasound or traction may also be used.

Possible Risk: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral disc, nerves or spinal cord. Cerebrovasular injury, or stroke, could occur upon severe injury to arteries of the neck. The ancillary procedures could produce skin irritation, burns or other minor complications.

Probability of Risk Occurring: The risk of complications due to Chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovasular injury, or stroke, has been estimated at one in one million to one in ten million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered the following:

- Over-the-counter analgesics. The risk of these medications include irritation to stomach, liver and kidneys. And other side effects in a significant number of cases.
- Medical care typically anti-inflammatory drugs, tranquilizers, and analgesics. Which of these drugs include multitude of undesirable side effects and patient dependence in a significant number of cases
- Hospitalization in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- Surgery in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risk of remaining Untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will condition, and make future rehabilitation more difficult.

Unusual Risks: I have had the following unusual risks of my case explained to me:

I have read the explanation above of chiropractic treatment. I have the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

Patient/Guardian Signature_____**DATE**_____

PAYMENT AUTHORIIZATION:

I request that payment of authorization health benefits be made to me or on my behalf of Traub Chiropractic Care Center of any services to me by the provider. I authorize any holder of medical information about me to be released to process any claim and any information needed to determine these benefits or the benefits payable for related services. This authorization is in effect until I choose to revoke.

IT IS ALSO MY RESPONSIBILITY TO SEE WHAT MY INSURANCE BENEFITS COVER FOR CHIROPRACITC

Patient/Guardian Signature_____**DATE**_____

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PRIVACY PRACTICE ACKNOWLEDGEMENT

I have received a copy of the Notice Privacy Practice.

Name_____Birthdate_____

Signature_____Date_____

Contact for Information, Questions, or Concerns

If you have questions or concerns about your privacy rights, these privacy-related policies or the information in this notice, please contact the doctor or the office manager where you are receiving care.

This notice is effective on or after April 14, 2003, unless and until it is revised by Traub Chiropractic Care Center.