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.
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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 Sex: F or M

Email:_____ Cell Phone Carrier:_____

Would you like to receive appointment reminders via: Email or Text or Neither? _____

Employer 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:
Blood Pressure_____ Pulse_____

Ht: _____ Wt_____

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: _____

Patient or 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

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.

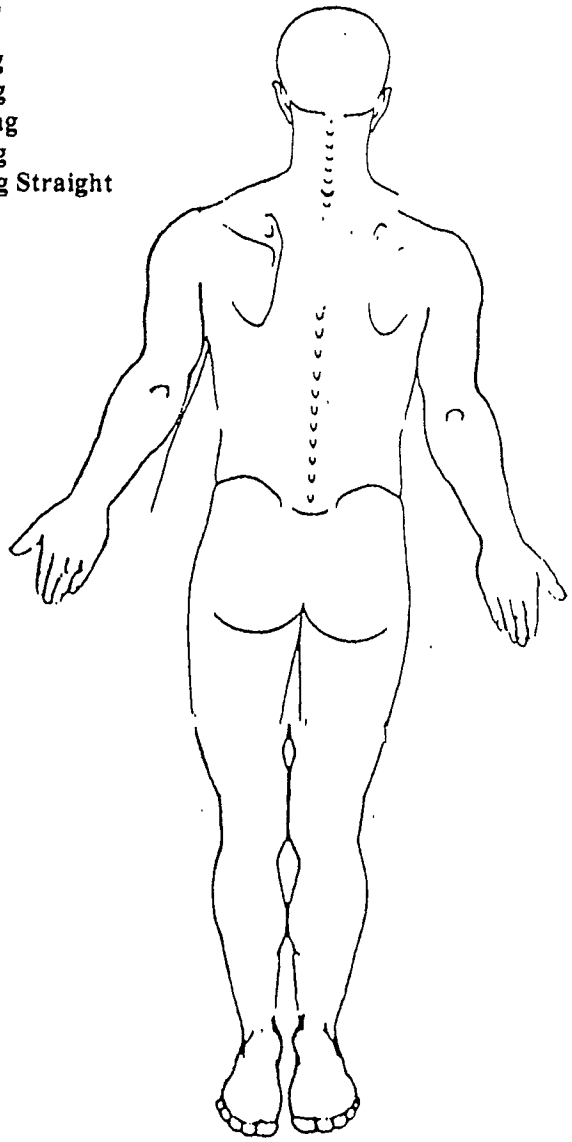
N = Numbness P = Pins & Needles B= Burning Pain S= Stabbing Pain A= Aching Pain

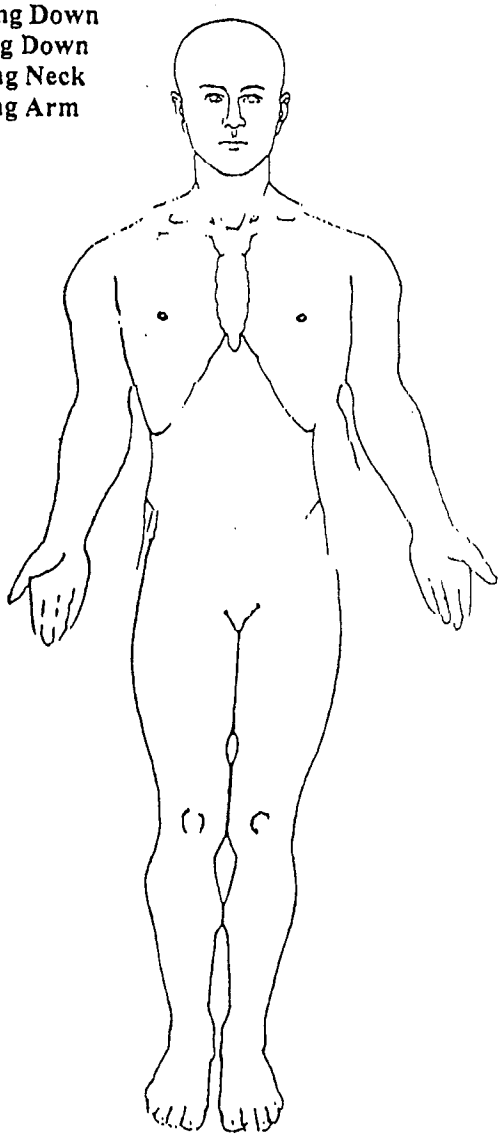
Low Back (√ below what makes it worse)

____ 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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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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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.

TRAUB CHIROPRACTIC CARE CENTER

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THIS NOTICE TAKE EFFECT ON APRIL 14, 2003 AND REMAINS IN EFFECT UNTIL WE REPLACE IT.

OUR PLEDGE REGARDING HEALTH INFORMATION

The privacy of your health information is important to us. We understand that your health information is personal and we are committed to protecting it. We create a record of the care and services you receive at our facility. We need this record to provide you with quality care and to comply with certain legal and professional requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of health information.

OUR LEGAL DUTY

The law requires us to keep your health information private, give you this notice describing our legal duties, privacy practices and your rights regarding your health information and follow the terms of the notice that is now in effect.

We have the right to change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law and make the changes in our privacy practices and the new terms of our notice effective for all health information that we keep, including information that we keep, including information previously created or received before the changes.

Before we make an important change in our privacy practice, we will change this notice and make the new notice available upon request.

USE AND DISCLOSURE OF YOUR HEALTH INFORMATION

The following section describes different ways that we use and disclose health information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your health information for any purpose not listed below. Without your specific written authorization. Any specific written authorization you Provide may be revoked at any time by writing to us.

FOR TREATMENT: We may use health information about you to provide you with chiropractic treatment or services. We may disclose health information about you to doctors, chiropractic assistants, staff and other people who are taking care of you. We may also share health information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your health information for payment purposes.

FOR HEALTH CARE OPERATIONS: We may use and disclose your health Information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you. We may use your health information to contact you regarding your appointments, to send you information about our clinic or office events, or share treatment options.

ADDITIONAL USES AND DISCLOSURES

In addition to using your health information for treatment, payment and health care options, we may use and disclose health information for the following purposes.

FAMILY AND FRIENDS FOR CARE AND PAYMENT: Unless you request otherwise and in emergency situations, we may disclose information to your family members, relatives, close friends, or others who are helping care for you or helping you pay your health care bills.

DISASTER RELIEF: We may disclose your health information to organizations for the purpose of disaster relief efforts.

RESEARCH IN LIMITED CIRCUMSTANCES: Health information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of health information.

REQUIRED BY LAW: We may disclose your health information when required by law to do so.

MILITARY, NATIONAL SECURITY, LAW ENFORCEMENT CUSTODY: We may disclose your health information to the proper authorities so they may carry out their duties under the law. This applies if you were involved with the military, national security or intelligence activities. It also applies if you were in custody of law enforcement officials or an inmate in a correctional institution.

PUBLIC HEALTH ACTIVITIES: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your health information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration.

VICTIMS OF ABUSE, NEGLECT, OR DOMESTIC VIOLENCE: We may disclose your health information, if we believe you have been a victim of abuse or neglect, to a government authority if required or allowed by law, or if you agree to the disclosure.

WORKERS COMPENSATION: We may disclose health information when authorized and necessary to comply with laws relating to workers compensation or other similar programs.

HEALTH OVERSIGHT ACTIVITIES: We may disclose health information to an agency providing health oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

LAW ENFORCEMENT: We may disclose your health information to law enforcement officials for specific purposes. For example when required by law to report certain injuries purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of health information.

YOUR INDIVIDUAL RIGHTS

As a patient who receives health care services from Traub Chiropractic Care Center you have the right to:

READ AND COPY YOUR HEALTH INFORMATION. You have the right to read and obtain a copy of your health information. We may charge you a reasonable fee if you want a copy of your health information. If we deny your request to review or obtain a copy you may submit a written request for a review of that decision.

REQUEST TO CORRECT YOUR HEALTH INFORMATION. If you believe there is an error in your health information or something has been left out, you may ask us to correct the information. You must make the request in writing and give the reason why your health information should be changed. If we did not create the information you believe is incorrect, or if we disagree with you and believe your health information is correct, we will deny your request. You may appeal to us in writing if we deny your request.

REQUEST TO RESTRICT CERTAIN USES AND DISCLOSURES OF YOUR INFORMATION. You have the right to ask that we restrict how your health information is used or disclosed. Under the law, we are not required to agree to your request. In some cases, we may not be able to agree to your request because we do not have a way to tell everyone who would need to know about the restriction there are other instances in which we are not required to agree with your request. We will inform you when we cannot find a way to carry out your request. You may request a restriction by discussing it with your doctor or staff member at the clinic where you have received treatment.

RECEIVE INFORMATION AT A DIFFERENT PLACE OR BY DIFFERENT MEANS. You have the right to ask that we send information to you in different ways or at different places. For example, you may wish to receive statements at an address other than your home address. We will grant reasonable request.

RECEIVE INFORMATION AT A DIFFERENT PLACE OR BY DIFFERENT MEANS. You have the right to ask us in writing for a list of places or persons to whom your health information was disclosed during the past six years. This list will not include disclosures for treatment, payment, health care operations and other exceptions as specified above or disclosures that occurred prior to April 14, 2003.

OBTAIN A PAPER COPY OF THIS NOTICE. Upon your request, you may at any time receive a paper copy of this notice. This notice is available at the front desk..

FILE A COMPLAINT. You have the right to file a complaint with us if you believe your privacy rights have been violated. To file a complaint, please call the clinic and speak to the doctor. You also have the right to complain to the United States Secretary of the Department of Health and Human Services. We will not take any action against you filing a complaint.