

Traub Chiropractic Care Center
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Patient Name: First _____ MI _____ Last _____

Address: _____

City _____ State _____ Zip _____

Home#() _____ Cell#() _____ Work#() _____

Email _____

Social Security # _____ Sex: Female or Male

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

Employers Name: _____ Full time _____ Part time _____

Physician Name: _____ Date last seen _____

Last Physical Exam Date: _____ Last X-ray Date: _____ MRI/CATSCAN _____

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

In the event of emergency notify name: _____ Phone: _____

Insurance Information

Insured's Name: _____ Insured's DOB: _____ Insured's Employer: _____

Secondary Insurer: _____ Insured's DOB: _____ Insured's Employer: _____

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.

Complaints: (Please list areas of complaint in order of severity)

1. _____ 3. _____

2. _____ 4. _____

When did the symptoms begin: _____ cause of complaint: _____

Have you seen another doctor for this? Y/N If so whom: _____

Are you currently under the care of a physician? Y/N If so, for what reason: _____

Have you ever had a similar symptoms before? Y/N _____

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

List all previous accidents/injuries or illnesses: _____

List all surgeries: _____

Have you ever been hospitalized? Y/N If yes, when and for what reason: _____

List conditions why medications/vitamins are needed: _____

Habits: Smoke Y/N Alcohol Y/N Exercise: Low Medium High

Patients/Guardian

Signature: _____ Date: _____

Please circle below symptoms that you:
A = ALWAYS HAVE
S = SOMETIMES HAVE
LEAVE BLANK IF NEVER HAD

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 on 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

INTERGUMENTARY & SKIN

- A OR S Boils
- A OR S Rash
- A OR S Change in moles/birthmarks
- A OR S Eczema
- A OR S Psoriasis

HEMATOLOGICAL/LYMPHITI

- A OR S Nose bleeds
- A OR S Bruising
- A OR S Swollen glands
- A OR S Sore throat

ALLERGIC/IMMUNOLOGICAL

- 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 of blood

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

FOR WOMEN ONLY

- A OR S Pain in breast
- A OR S Breast lump
- A OR S Irregular cycle
- A OR S Painful menstruation
- No cycle _____
- Menopause _____
- Hysterectomy _____
- Are you pregnant _____
- No. of children _____

CONDITIONS

- Alcoholism _____
- Anemia _____
- Appendicitis _____
- Cancer _____
- Chicken pox _____
- Measles _____
- Gout _____
- Diabetes _____
- Epilepsy _____
- Pneumonia _____
- Emphysema _____
- Polio _____
- Insomnia _____
- Strain/sprains _____
- Broken bones _____
- Rheumatic fever _____
- Struck unconscious _____
- Multiple Sclerosis _____
- Fibromyalgia _____
- Asthma _____