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