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

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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: _____

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:**

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 Guardian 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)**

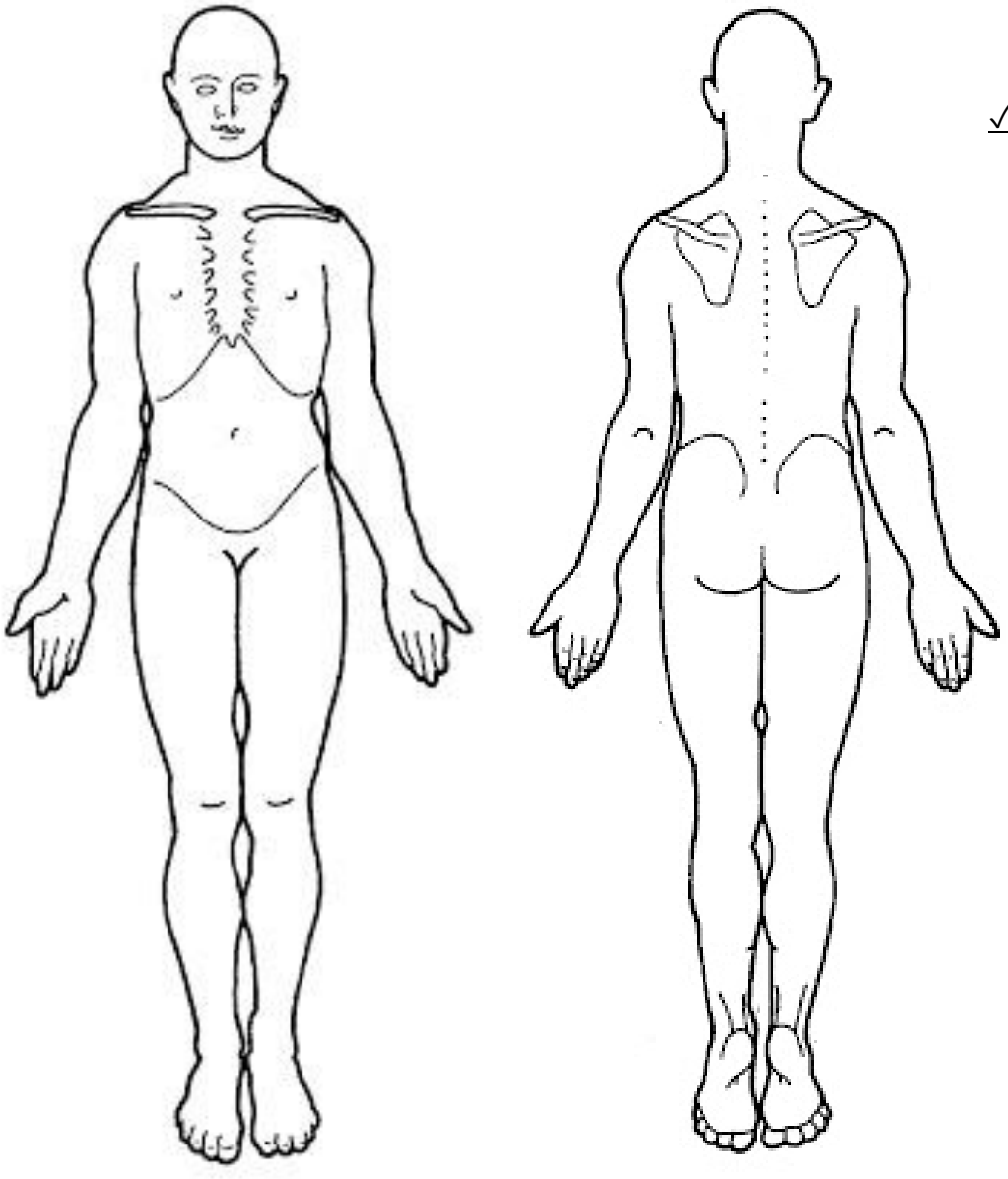
Alcoholism
Anemia
Appendicitis
Cancer
Chicken Pox
Measles
Gout
Diabetes
Epilepsy
Pneumonia
Emphysema
Polio
Insomnia
Strain/Sprain
Broken Bones
Rheumatic Fever
Struck Unconscious
Multiple Sclerosis
Fibromyalgia
Asthma

## Pain Drawing

Name:_____ Date:_____

Please be sure to full 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 S = Stabbing Pain A = Aching Pain



✓ below what makes it worse

___ Turning Head
___ Looking Up
___ Looking Down
___ Laying Down
___ Moving Neck
___ Raising Arm
___ Sitting
___ Standing
___ Bending
___ Walking
___ Twisting
___ Sneezing
___ Driving
___ Sit to Stand

**ON A 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

### Lifting

0 = No pain with heavy weight
1 = increased pain with heavy weight
2 = Increased pan 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 = Increases 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 few activities

NAME_____TOTAL SCORE _____

SIGNATURE_____DATE_____

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## INFORMED CONSTENT 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 joints. 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 the intervertebral disc, nerves or spinal cord. Cerebrovascular 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 cerebrovascular injury, or stroke, has been estimated at one on 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 are 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 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 the delay of treatment can 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 had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and the benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

**Patient Name: _____ DOB: _____**

**Patient/Guardian Signature:_____ Date_____**

## PAYMENT AUTHORIZATION

I request that payment of authorized health benefits be made to Traub Chiropractic Care Center for any services given to me by the provider. I authorize to 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.

Traub Chiropractic may verify my chiropractic coverage; however, this is an estimation of benefits and not a guarantee of coverage. Any estimated copays are due at time of service. I understand I am liable for any non-covered charges and any remaining patient responsibility amount.

**Patient/Guardian Signature**:_____ **Date**_____

## 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.

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## CONSENT TO TREAT A MINOR

I hereby authorize Traub Chiropractic Care Center's doctors, together with whomever my treating doctor may designate as an appropriate individual(s) to administer chiropractic care, including X-rays, and appropriate adjunctive services as my treating chiropractor deems is necessary to my child. I acknowledge that I have legal authority to provide such written consent on behalf of such child/ward.

Patient (child/ward) _____ DOB: _____

Signature: _____ Date_____

Relation: _____

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# AUTHORIZATION FOR EMAIL

Patient Name _____ Date of Birth: _____

## I understand that:

- Email messages are inherently unsecure because Traub Chiropractic Care Center uses unencrypted email server and as such there are inherent risks in using this type of communication. Information emailed to me could be received and read by an unauthorized third party.
- It is my responsibility to keep my email address up to date with Traub Chiropractic Care Center.
- I should not send PHI or ePHI to Traub Chiropractic Care Center in an email message because of the unsecure nature of the unencrypted electronic transmissions.
- This Authorization is voluntary, and I have the right to refuse to sign it.
- Treatment will not be conditional on whether I sign this Authorization.
- By signing this form, I am allowing Traub Chiropractic Care Center to send email messages to the following email address: _____ in order to:
    - Notify me of appointment confirmations, reminders or missed appointments
    - Other _____
- Traub Chiropractic Care Center will not send PHI or sensitive PHI in an email message.
- If I sign this authorization, I may revoke (cancel or opt out) it later, at any time, by replying to an email and stating your name and that you would like to opt out of email communication.

**Signature(s)**

Patient signature _____ Date _____

*Sign below if you are a personal representative of the patient.*

Representative signature_____ Date _____

Print Name _____ Relationship to Patient _____

**Definitions:**

**Protected Health Information (PHI)**: PHI means information about a patient, including demographic information that may identify a patient, that relates to the patient's past, present or future physical or mental health or condition, related health care services or payment for health care services.

**Sensitive Protected Health Information (SPHI)**: SPHI means Protected Health Information that pertains to particularly sensitive information, as defined by state law, such as (i) an individual's HIV status or treatment of an individual for an HIV-related illness or AIDS, or (ii) an individual's substance abuse condition or treatment of an individual for mental illness.

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# AUTHORIZATION FOR TEXT MESSAGING

Patient Name _____ Date of Birth: _____

**I understand that:**

- Text messages are inherently unsecure because they are transmitted over a public network onto a personal telephone and as such there are inherent risks in using this type of communication. Information texted to me could be received and read by an unauthorized third party.
- It is my responsibility to keep my mobile number and cell phone carrier up to date with Traub Chiropractic Care Center.
- I should not send PHI or ePHI to Traub Chiropractic Care Center in a text message because of the unsecure nature of text messages.
- I may be charged for text messages by my wireless carrier.
- This Authorization is voluntary, and I have the right to refuse to sign it.
- Treatment will not be conditional on whether I sign this Authorization.
- By signing this form, I am allowing Traub Chiropractic Care Center to send text messages to the following mobile number: _____ with the following cell phone carrier: _____ in order to:
  (Verizon, US Cellular, AT&T, Etc.)
  - Notify me of appointment confirmations, reminders or missed appointments
  - Other _____
- Traub Chiropractic Care Center will not send PHI or sensitive PHI in a text message.
- If I sign this authorization, I may revoke (cancel or opt out) it later, at any time, by replying to a text and stating your name and that you would like to opt out of text communication.

**Signature(s)**

Patient signature _____ Date _____

*Sign below if you are a personal representative of the patient.*

Representative signature_____ Date _____

Print Name _____ Relationship to Patient _____

**Definitions:**

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