Traub Chiropractic Care Center
N58 W39799 Hwy 16 Oconomowoc, WI 53066
Ph: 262-567-4497/traubchiro@gmail.com
Website: traubchiropractic.com

Patient Name: First _____ MI____ Last_____ Nickname _____

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

Mailing Address: _____

City: _____ State: _____ Zip: _____

Cell#: (____)_____ Other: □work □home #: (____) _____

Email: _____

In event of emergency, contact: _____ Phone: _____

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? _____

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: _____

Signature: _____ Date: _____

Other Side

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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

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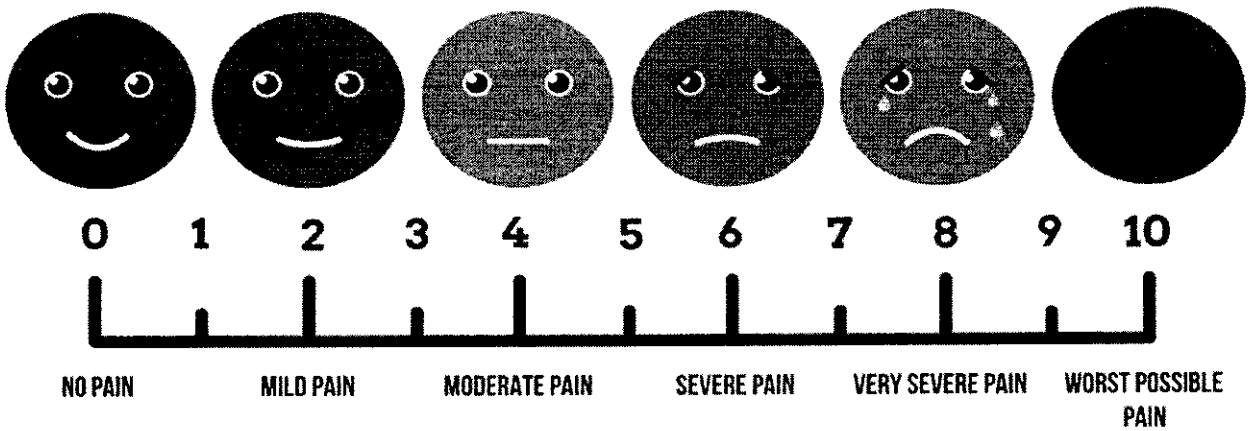
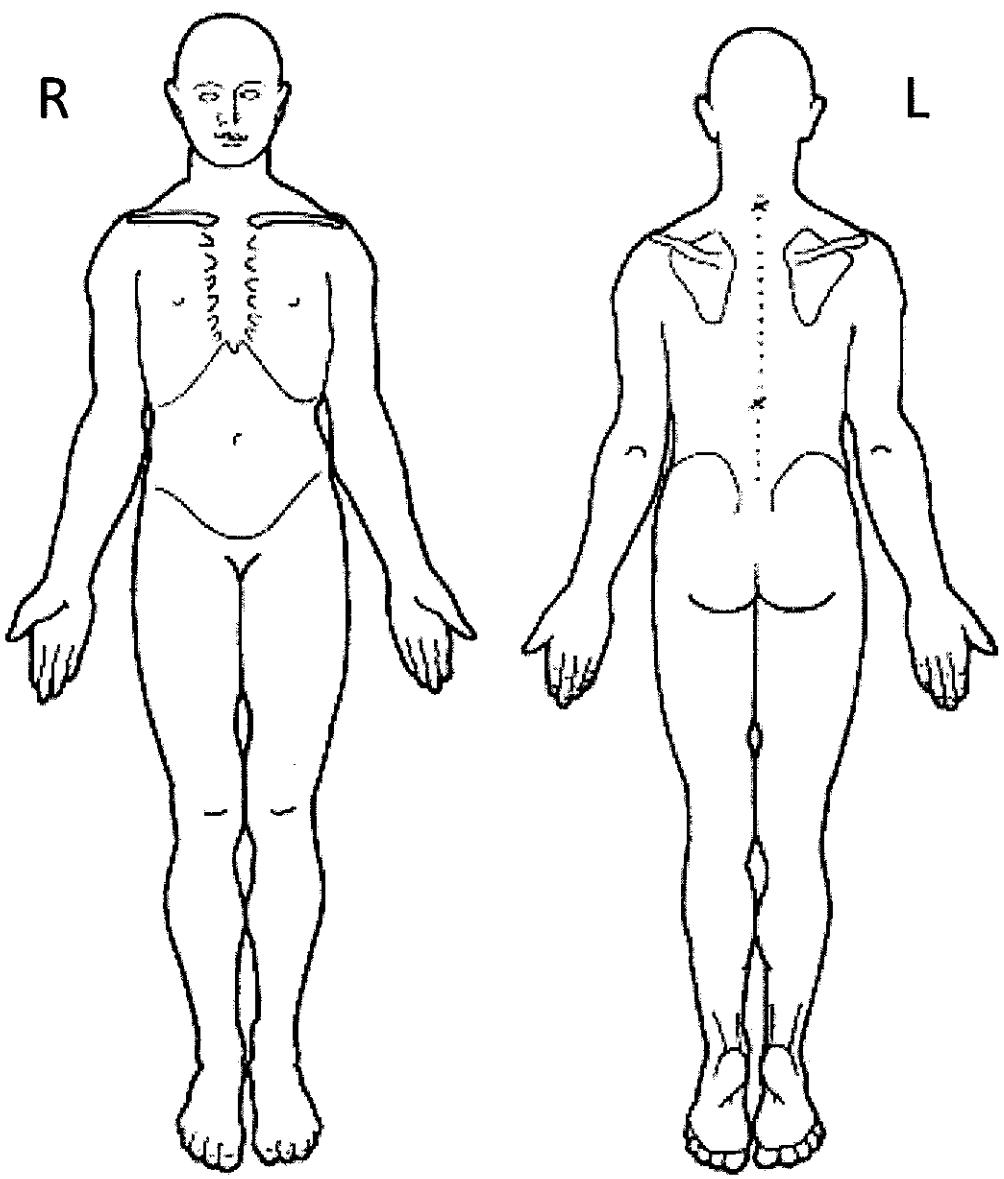
Name:_____ **Date:**_____



Circle a number <u>above</u> to describe your pain intensity AND mark or circle on the bodies <u>below</u> to show the location of any symptom(s) you have been experiencing recently.



Functional Rating Index

For use with Neck and/or Back Problems only.

In order to properly 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 which most closely describes your condition right now.**

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1. Pain Intensity

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

2. Sleeping

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

3. Personal Care (washing, dressing, etc.)

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

4. Travel (driving, etc.)

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

5. Work

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

6. Recreation

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

7. Frequency of pain

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

8. Lifting

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

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

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

Name _____
PRINTED

_____
Signature

_____
Date

Total Score _____

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INFORMED CONSTENT TO CHIROPRACTIC TREATMENT

The Nature of Chiropractic Treatment: The doctor will perform a physical examination. X-rays may be taken to evaluate your condition. The doctor will use his/her hands or a mechanical device in order to move our joints. You may feel a "click" or "pop" similar to the noise produced when a knuckle is "cracked," and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound, or traction maybe also be used. Exercises may be recommended.

Benefits of Chiropractic Treatment: Many or most patients will feel improvement in motion, decreased muscle and joint pain and improved well-being after a series of chiropractic adjustments.

Possible Risk: As with any health care procedure, complications are possible following chiropractic treatment. Complications could conceivably include fracture of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves, or spinal cord. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, urns, or other minor complications. X-rays produce ionizing radiation. There are reported cases of stroke associated with visits to medical doctors and/or chiropractors. The best quality scientific evidence does not establish a cause-and-effect relationship between chiropractic treatment and the occurrence of stroke; rather, indicate that patients may be consulting medical doctors and/or chiropractors for symptoms of headache and neck pan when they are in the early stages of a stroke. The possibility of such injuries occurring in association with chiropractic treatment is extremely remote.

Probability of Risk Occurring: The risk of complications due to chiropractic treatment have been described as "rare" to "extremely 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, increased cardiovascular risk, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these prescription drugs include all side effect as above, plus patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to medical error, infection and other complications in 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 will complicate the condition and make future rehabilitation more difficult,

I have had the above 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. This informed consent will remain in effect unless there are significant changes in my diagnosis or my legal status. I have the right to withdraw my consent at any time, upon written notice. I have the right to refuse treatment at any time.

Printed Name: _____ **DOB:** _____

Signature: _____ **Date:** _____

Staff Initials: _____

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Patient Name: _____ **DOB:** _____

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.

Signature:_____ **Date**_____

PRIVACY PRACTICE ACKNOWLEDGEMENT

I understand that a copy of the HIPAA policy is available for me at any time and a copy is posted in a common area of the clinic.

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.

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.

Signature of Parent or Guardian: _____ **Date**_____

Relation to Child: _____

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AUTHORIZATION FOR TEXT AND EMAIL

Patient Name _____ Date of Birth: _____

I understand that:

- Text messages and emails 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 email up to date with Traub Chiropractic Care Center.
- I should not send PHI or ePHI to Traub Chiropractic Care Center in a message because of the unsecure nature of text messages and emails.
- 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 me messages in order to:
    - Notify me of appointment confirmations, reminders or missed appointments
    - Special messages, promotions, office updates
    - Other _____
- Traub Chiropractic Care Center will not send PHI or sensitive PHI in a message.
- If I sign this authorization, I may revoke (cancel or opt out) it later, at any time, by replying "STOP" to a text or unsubscribing from email communications.

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.