CONFIDENTIAL PATIENT HEALTH HISTORY

WHITE OAKS CHIROPRACTIC | DR. STEPHEN J. BAKO

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PATIENT DETAILS

Date: _____ Sex: Male Female Other

Name: _____ Preferred Name (if different): _____

Date of Birth: M_____/D_____/Y_____ Age: _____ Marital Status: S M D W

Address: _____ City: _____

Postal Code: _____ Phone: _____ Home Cell

EMail: _____ Occupation:_____

Family Physician: _____ Spouse's Name: _____

Number of children & ages: _____

Who can we thank for referring you to us?_____

TODAY'S VISIT

What brings you to our office today? Circle all that apply.

New Injury/Problem Reoccurrence/Worsening of Existing Condition Wellness/Lifestyle

If you have a specific concern, please describe:

_____

_____

How and when did this problem start? _____

Have you ever received chiropractic care before? **Yes** **No**

If yes, when and where? _____

What was your experience like?

_____

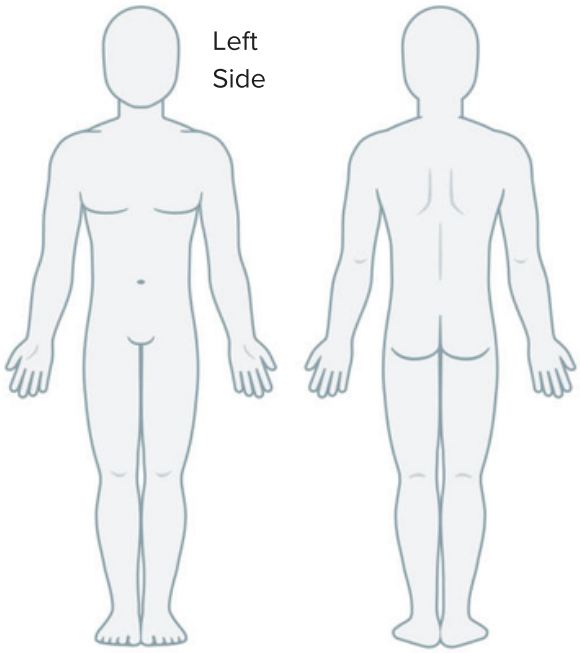
Is today's visit due to a motor vehicle accident? **Yes** **No**

If yes, what was the date of the accident?_____

WITH REGARDS TO PAIN YOU MAY BE EXPERIENCING

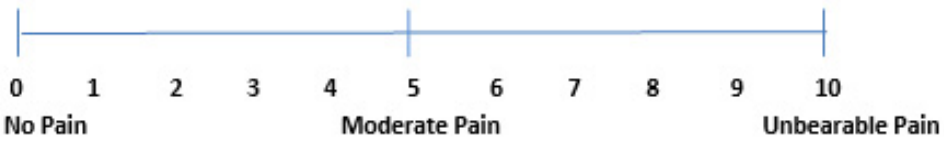
Using the diagram and symbols below please indicate where you feel sensations of pain:

Numbness ### **Pins/Needles** - - - - **Burning** oooo
Sharp X X X X **Dull/Achy** △△△ **Stiff/Tight** 2222



If experiencing multiple problem areas, please list in order of concern:

1.
2.
3.



Please circle all that apply.

Is the problem/symptom.... *Constant* *Intermittent (comes & goes)* *Only with movement*

is the condition worse.... *In the morning* *In the evening* *With movement*

What activities or aspects of your life would you like to be able to do without pain or discomfort?

_____

_____

The condition is progressively getting worse: Yes No

What aggravates your condition:

_____

_____

What relieves your condition/pain?:

_____

_____

HOW DO YOU CURRENTLY MANAGE YOUR SYMPTOMS?

Please select all that apply.

☐ Ice ☐ Heat ☐ Stretching/Exercise ☐ Vitamins ☐ Prescription Medications

☐ Rubs or Gels ☐ Diet Changes ☐ Stress Reduction ☐ Aspirin or Tylenol

☐ Surgery ☐ Chiropractic Care ☐ Massage/Body Work

☐ Naturopathic Care ☐ Acupuncture Other: _____

Have any x-rays, CAT or MRI been taken of the area? _____

Have you ever suffered from any of the following?:

Circle		Circle	
Past / Present	**Headaches**	Past / Present	**Ears ring**
Past / Present	**Blood pressure problems**	Past / Present	**Nervousness**
Past / Present	**Frequent colds**	Past / Present	**Nose/Sinus problems**
Past / Present	**Fatigue**	Past / Present	**Dizziness/ balance issues**
Past / Present	**Allergies**	Past / Present	**Asthma/lung problems**
Past / Present	**Skin problems**	Past / Present	**Fainting**
Past / Present	**Depression**	Past / Present	**Tension**
Past / Present	**Irritability**	Past / Present	**Frequent Nausea**
Past / Present	**chest pains**	Past / Present	**Heart Problems**
Past / Present	**Sleep Problems**	Past / Present	**Menstrual problems**
Past / Present	**Diarrhea**	Past / Present	**Constipation**
Past / Present	**Digestive Disorders**	Past / Present	**Kidney problems**
Past / Present	**Bladder Problems**	Past / Present	**Numbness or pins & needles in the arms/legs**
Past / Present	**Cold feet/hands**		
Past / Present	**Arthritis**		

If you said yes to arthritis, where?_____

If none of the above apply, check here: ☐

PLEASE LIST ANY SURGERIES AND SIDE EFFECTS YOU MAY HAVE EXPERIENCED

If you have not undergone any surgeries please check here: ☐

_____ **when?**_____

_____ **when?**_____

_____ **when?**_____

_____ **when?**_____

_____ **when?**_____

_____ **when?**_____

_____ **when?**_____

PLEASE LIST YOUR PRESCRIPTION MEDICATIONS / SUPPLEMENTS

If you are not taking any medications or supplements please check here: ☐

_____ **for?**_____

_____ **for?**_____

_____ **for?**_____

_____ **for?**_____

_____ **for?**_____

FAMILY HISTORY

	Heart Disease	Stroke	Cancer	Arthritis	Diabetes	Depression	Other:_____
Father's Side	☐	☐	☐	☐	☐	☐	
Mother's Side	☐	☐	☐	☐	☐	☐	

EVENTS AND HABITS

Please indicate YES or NO to the best of your ability for each. Feel free to add additional comments.

Your Birth

Yes / No Was it a vaginal birth?
Yes / No Were forceps/vaccuum extraction used?
Yes / No Was your mother given medication prior to or during delivery?

Growing Years

Yes / No Did you receive chiropractic care as a child?
Yes / No Were you breast fed?
Yes / No Any significant childhood injuries or illnesses?
Yes / No Any childhood surgeries/ prolonged medications?
Yes / No Any notable falls/ injuries/ head injuries/ broken bones?
Yes / No Did you play any competitive sports?
Yes / No Subject of mental or physical abuse?

Adulthood

Yes / No Any past motor vehicle / boating / snow mobile accidents?
Yes / No Have you had any notable falls/ injuries as an adult?
Yes / No Are you able to sustain proper posture?
Yes / No Do you exercise regularly? If yes, how often? _____
Yes / No Does your job/daily routine require you to sit for long periods of time? (desk, flying, driving)

Stresses

Yes / No Do you smoke or drink alcohol? Please specify which, and how often: _____
Yes / No Do you eat as healthy as you think you should?
Yes / No Are you or have you ever been overweight?
Yes / No Are you exposed to chemicals or fumes? (ie. hairdresser, factory, construction, etc)
Yes / No Do you experience occupational/work stress?
Yes / No Mental Stress?

CHIROPRACTIC CARE

There are three phases of chiropractic care:

- **Initial Intensive Care:** This phase focuses on relieving acute pain and discomfort. It typically involves frequent adjustments to address immediate issues, such as injury or severe misalignments, with the goal of reducing pain and inflammation quickly.

- **Corrective Care:** After the initial relief, corrective care aims to address the root causes of the problem and improve spinal function over time. This phase involves more targeted adjustments to correct misalignments and restore optimal posture and movement patterns, often requiring fewer visits.

- **Wellness Care:** This ongoing phase focuses on maintaining optimal health and preventing future issues. Wellness care involves periodic adjustments to keep the spine aligned and the nervous system functioning at its best, promoting overall health and well-being.

These will be discussed in more depth at your report of findings appointment.
Then you'll be able to begin a care plan that fits your health goals.

EXPECTATIONS AND GOALS

What is your ideal outcome from chiropractic care?

Are you open to long-term care for wellness, or are you looking for relief from a specific issue?

How much time are you willing to dedicate to achieving your health goals through chiropractic care?

Is there anything specific you want to know or feel unsure about regarding chiropractic care?

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

WHITE OAKS CHIROPRACTIC

There are risks and possible risks associated with manual therapy techniques used by Doctors of Chiropractic.

In particular you should note:

a) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures.

b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke. Recent studies suggest that patients may be consulting medical doctors and chiropractors when they are in the early stages of stroke. In essence there is a stroke already in progress. However, you are being informed of this reported association because stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote.

c) There are rare, reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused by spinal adjustments or other chiropractic treatment.

I acknowledge I have read this consent form and I have discussed or have been offered the opportunity to discuss with my chiropractor the nature and purpose of chiropractic treatment in general (including the spinal adjustment), the treatment options, and recommendations for my condition and the contents of this consent.

I hereby give my consent to the performance of chiropractic examinations, adjustments and other chiropractic procedures on me by any doctor named below at White Oaks Chiropractic. I consent to the treatment recommended to me by my chiropractor including any recommended spinal adjustments.
I intend this consent to apply to all my present and future chiropractic care.

Patient Name: _____ **Patient Signature:** _____

Doctor: Dr. Stephen J. Bako, DC _____

If you are the parent or legal guardian of a minor patient (under age 16) please sign on their behalf to provide consent.

X- Ray Consent

I hereby authorize the performance of diagnostic x-rays. The Doctor has requested the x-rays for further diagnostic purposes. At this time I know of no other condition which the taking of x-rays would further complicate.

Further, I certify to the best of my knowledge that I am NOT pregnant (if applicable). I am aware that taking x-rays, particularly those involving the pelvis, can be hazardous to an unborn child.
Please note these radiographs are not covered by OHIP, but may be covered by your extended benefits provider.
X-rays range from $68-$140.

Patient / Guardian Initial: _____ **Date:** _____