CONFIDENTIAL PEDIATRIC 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: _____/_____/_____ Age: _____

Address: _____ City: _____

Postal Code: _____

Parent/Guardian & Contact Phone: _____

EMail:_____

Family Physician: _____

Has your child ever received chiropractic care? : Yes Where? _____ No

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:

_____

_____

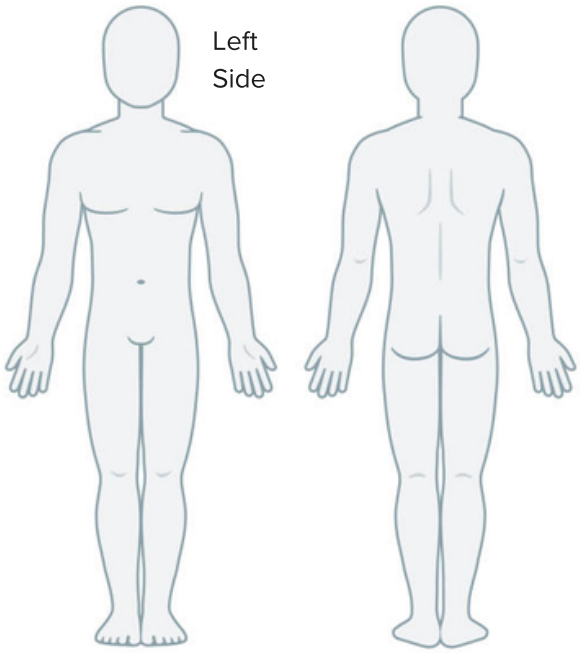
How and when did this problem start? _____

WITH REGARDS TO PAIN YOU MAY BE EXPERIENCING

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

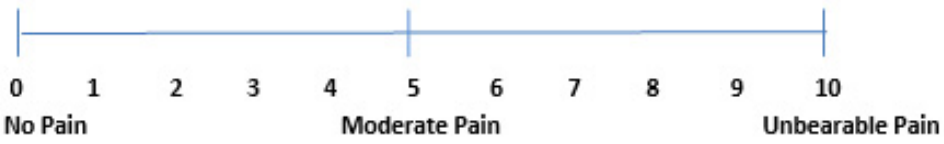
Numbness ### **Pins/Needles** - - - - **Burning** oooo

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?:

_____

_____

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.

Birth

Yes / No Was it a vaginal birth?
Yes / No Assisted birth - Were forceps/vaccuum extraction used? C-Section? _____
Yes / No Was the mother given medication prior to or during delivery?

Growth & Development

Yes / No Developmental milestones met on time?
Yes / No Sleeping patterns seem "normal" ?
Yes / No Any surgeries or prolonged medications?
Yes / No Any notable falls/injuries?

Yes / No Breast-fed? How long? _____
Yes / No Formula introduced at age: _____
Yes / No Introduced cow's milk at age: _____
Yes / No Food/juice intolerances? Type: _____
Yes / No Began solid foods at age: _____
Yes / No Picky eater
Yes / No Did the mother smoke during pregnancy>
Yes / No Did the mother suffer an illness during pregnancy>
Yes / No Supplements taken during pregnancy?_____
Yes / No Drugs during pregnancy:_____
Yes / No Exposure to ultrasound? How many and when? _____
Yes / No Invasive procedures (amniocentesis, CVS) _____
Yes / No Any pets at home? _____
Yes / No Any smokers at home?_____
Yes / No Vaccinations: Which ones? Any reactions? _____
Yes / No Antibiotics? Number of courses to date?_____

Psychosocial

Yes / No Difficulties with lactation?
Yes / No Problems bonding?
Yes / No Behavioural problems? Onset? _____
Yes / No Daycare? Age started: _____
Yes / No Night terrors/ sleep walking?
Average number of hours of TV/computer use per week? _____

Stresses

Yes / No Traumas during pregnancy? (falls, accidents?)
Yes / No Was your child ever in a motor vehicle accident?
Yes / No Notable falls/injuries?
Yes / No Any hospitalizations?
Yes / No Any surgeries?
Yes / No Any head injuries/broken bones?
Yes / No Sports played? Began at age: _____
Hours per week?_____
Yes / No Backpack weight seems excessive?

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

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?**_____

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.

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 child's chiropractor the nature and purpose of chiropractic treatment in general (including the spinal adjustment), the treatment options, and recommendations for my child's condition and the contents of this consent.

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

Patient Name: _____

Parent/Guardian Signature: _____

Doctor: Dr. Stephen J. Bako, DC _____

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, including but not limited to pregnancy. I am aware that taking x-rays, particularly those involving the pelvis, can be hazardous to an unborn child.

Patient / Guardian Initial: _____

Date: _____