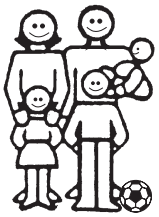

**WAGNER**
Chiropractic Health
& Wellness Centres

*"Where your journey to wellness begins..."*

CHIROPRACTIC CHIROPRATIQUE Ontario MEMBER

25 Centre Street West, **Strathroy**, ON N7G 1T5
**Tel: 519-245-0946 Fax: 519-245-3938**

251 Main Street, **Parkhill**, ON N0M 2K0
**Tel: 519-294-0373 Fax: 519-294-0414**

**www.wagnerwellnesscentres.com**

## PERSONAL INFORMATION

❑ Miss ❑ Mrs. ❑ Ms. ❑ Mr. How would you like to be addressed? _____

NAME _____ DATE _____

ADDRESS _____ CITY _____ POSTAL CODE _____

Home Phone _____ Business Phone _____ Ext. ____ Cellular/Other _____

Date of Birth ____ / ____ / ____ E-mail _____ Gender ❑ M ❑ F Age _____
D M Y

Occupation or Profession _____ Employed by _____

MARITAL STATUS ❑ Single ❑ Married ❑ Divorced ❑ Widowed Number of Children _____

Name of M.D. _____ Spouse/Support Person _____ Name and Ages _____

Who referred you to our clinic? _____ _____

EXTENDED COVERAGE ❑ NO ❑ YES (Blue Cross, Great West Life, Green Shield) _____

### YOUR HEALTH PROFILE

Have you been to a chiropractor previously? ❑ NO ❑ YES When: _____ Doctor: _____

***WHY THIS FORM IS IMPORTANT.***

As a full spectrum chiropractic office we focus on your ability to be healthy. Our first goal is to address the issues that brought you here and secondly to offer you the opportunity of improved health, wellness and quality of life in the future. On a daily basis, we will experience physical, chemical and psychological/emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual and may not even be felt until they become serious. Answering the following questions will give us a profile of the specific stresses – past and present – that you face and allow us to better assess the challenges to your health potential.

## ADDRESSING WHAT BROUGHT YOU TO THIS OFFICE

Please briefly describe your chief concern, including the effect it has had on your life.

_____

_____

If we find the cause of your problem and show you how to correct it, what is the one thing you would love to be able to do?

_____

| Health Concerns: List health concerns according to their severity. | Rate of Severity 1 = mild 10 = worst | When did this episode start? | If you had the condition before, when? | Did the problem begin with and injury? | Are symptoms constant or intermittent? |
|---|---|---|---|---|---|
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |

If you are experiencing pain, is it ❑ Sharp ❑ Dull ache

Does the pain travel/radiate anywhere: ❑ No ❑ Yes, please describe

_____

_____

Since the problem started, it is:
❑ About the same ❑ Getting better ❑ Getting worse
What have you done for this condition that has helped you feel better? (relieving)_____

What makes this condition worse?_____

Do you have a family history of this or similar symptoms? ❑ No ❑ Yes, please explain _____

Is this condition interfering with your ❑ Work ❑ Leisure ❑ Sleep ❑ Sports/exercise/walking ❑ Positive mental attitude ❑ Hobbies

❑ Other_____

Have you had to, or felt the need to make any "positive" changes in your life due to your condition? (i.e. eat better, less alcohol or drugs, meditate, less destructive sports/activities etc.) If so, what?

Other doctors/therapists seen for ***this*** problem (please list): Chiropractor:_____ Medical Doctor:_____

Other:_____

## ABOUT YOUR HEALTH

The human body is designed to be healthy. Throughout life, events occur which damage your health expression. This case history will uncover the layers of damage, especially to your nerve system, that have resulted in your lowered state of health. At your report of findings, your chiropractor will outline a course of care to begin to correct these layers of damage and recover your innate health potential.

**PRESENT HEALTH:** Are you presently affected by any of the following? (within the past 3 months)

**O - OCCASIONAL F - FREQUENT C - CONSTANT**

| MUSCLE AND JOINT | O | F | C |
|---|---|---|---|
| Backache | ❑ | ❑ | ❑ |
| Neck pain | ❑ | ❑ | ❑ |
| Painful tailbone | ❑ | ❑ | ❑ |
| Foot trouble | ❑ | ❑ | ❑ |
| Shoulder trouble | ❑ | ❑ | ❑ |
| Hernia | ❑ | ❑ | ❑ |
| Spinal curvature | ❑ | ❑ | ❑ |
| Faulty posture | ❑ | ❑ | ❑ |
| Arthritis | ❑ | ❑ | ❑ |

| STRESS SYMPTOMS | | | |
|---|---|---|---|
| Headache/Migraine | ❑ | ❑ | ❑ |
| Dizziness | ❑ | ❑ | ❑ |
| Numbness or pins & needles in arms/hands, legs/feet | ❑ | ❑ | ❑ |
| Ringing in ears | ❑ | ❑ | ❑ |
| Blurring of vision | ❑ | ❑ | ❑ |
| Loss of sleep | ❑ | ❑ | ❑ |
| Loss of concentration and/or memory | ❑ | ❑ | ❑ |
| Irritable/Nervousness | ❑ | ❑ | ❑ |
| Depression | ❑ | ❑ | ❑ |
| Decreased Energy/Fatigue | ❑ | ❑ | ❑ |
| Tension | ❑ | ❑ | ❑ |

| GENERAL SYMPTOMS | O | F | C |
|---|---|---|---|
| Fever/Chills/Sweat | ❑ | ❑ | ❑ |
| Fainting | ❑ | ❑ | ❑ |
| Convulsions | ❑ | ❑ | ❑ |
| Allergy | ❑ | ❑ | ❑ |
| Skin problems | ❑ | ❑ | ❑ |
| Colds | ❑ | ❑ | ❑ |
| Tremors | ❑ | ❑ | ❑ |
| Loss of balance | ❑ | ❑ | ❑ |

| RESPIRATORY | | | |
|---|---|---|---|
| Chronic cough | ❑ | ❑ | ❑ |
| Spitting up phlegm/blood | ❑ | ❑ | ❑ |
| Chest pain | ❑ | ❑ | ❑ |
| Difficult breathing | ❑ | ❑ | ❑ |

| URINARY | | | |
|---|---|---|---|
| Painful urination | ❑ | ❑ | ❑ |
| Getting up at night to urinate | ❑ | ❑ | ❑ |
| Blood in urine | ❑ | ❑ | ❑ |

Increased urination ❑ Yes ❑ No

| GASTROINTESTINAL | O | F | C |
|---|---|---|---|
| Difficult digestion | ❑ | ❑ | ❑ |
| Belching or gas | ❑ | ❑ | ❑ |
| Nausea or vomiting | ❑ | ❑ | ❑ |
| Pain over stomach | ❑ | ❑ | ❑ |
| Constipation | ❑ | ❑ | ❑ |
| Colon trouble | ❑ | ❑ | ❑ |
| Liver trouble | ❑ | ❑ | ❑ |
| Gall bladder trouble | ❑ | ❑ | ❑ |
| Heartburn | ❑ | ❑ | ❑ |
| Diarrhea | ❑ | ❑ | ❑ |
| Bloody stools | ❑ | ❑ | ❑ |

| EYES, EAR, NOSE, THROAT | | | |
|---|---|---|---|
| Deafness | ❑ | ❑ | ❑ |
| Earache | ❑ | ❑ | ❑ |
| Sore throat | ❑ | ❑ | ❑ |
| Asthma | ❑ | ❑ | ❑ |
| Tonsillitis | ❑ | ❑ | ❑ |
| Sinus trouble | ❑ | ❑ | ❑ |

| CARDIOVASCULAR | O | F | C |
|---|---|---|---|
| Rapid heart beat | ❑ | ❑ | ❑ |
| Slow heart beat | ❑ | ❑ | ❑ |
| High blood pressure | ❑ | ❑ | ❑ |
| Low blood pressure | ❑ | ❑ | ❑ |
| Pain over heart | ❑ | ❑ | ❑ |
| Swelling of ankles | ❑ | ❑ | ❑ |
| Previous heart attack | ❑ Yes | ❑ No | |
| Poor circulation | ❑ Yes | ❑ No | |
| Previous stroke | ❑ Yes | ❑ No | |

| FEMALES ONLY | | | |
|---|---|---|---|
| Painful menstruation | ❑ | ❑ | ❑ |
| Excessive flow | ❑ | ❑ | ❑ |
| Irregular | ❑ | ❑ | ❑ |
| Cramps or backache | ❑ | ❑ | ❑ |
| Abnormal discharge | ❑ | ❑ | ❑ |
| Passed menopause | ❑ | ❑ | ❑ |
| Are you pregnant | ❑ | ❑ | ❑ |
| Birth control pill | ❑ | ❑ | ❑ |

**NAME:** _____ **FILE #:** _____ WAGNER Chiropractic Health & Wellness Centres

**PAST HEALTH:** Have you ever suffered from any of the following conditions?

| | | | |
|---|---|---|---|
| Thyroid trouble . . . . . ❑ Yes ❑ No | Tuberculosis. . . . . ❑ Yes ❑ No | Emotional problems . . ❑ Yes ❑ No | Psoriasis . . . . . ❑ Yes ❑ No |
| Diabetes. . . . . ❑ Yes ❑ No | Neck pain . . . . . ❑ Yes ❑ No | Epileptic seizures . . . . ❑ Yes ❑ No | Polio . . . . . ❑ Yes ❑ No |
| High blood pressure . . ❑ Yes ❑ No | Back pain . . . . . ❑ Yes ❑ No | Asthma. . . . . ❑ Yes ❑ No | Cancer . . . . . ❑ Yes ❑ No |
| Heart disease . . . . . ❑ Yes ❑ No | Headaches. . . . . ❑ Yes ❑ No | Arthritis. . . . . ❑ Yes ❑ No | Venereal disease . . . . ❑ Yes ❑ No |
| Allergies . . . . . ❑ Yes ❑ No | Stomach ulcers. . . . . ❑ Yes ❑ No | Alcoholism . . . . . ❑ Yes ❑ No | HIV . . . . . ❑ Yes ❑ No |

List any medications you are taking and why:
(***prescription and non-prescription)*** _____

_____

Accidents and/or injuries: auto, work related, or other (especially those related to your present problems).

1. Type _____ Date _____ Hospitalized ❑ Yes ❑ No
2. Type _____ Date _____ Hospitalized ❑ Yes ❑ No
3. Type _____ Date _____ Hospitalized ❑ Yes ❑ No
4. Type Date Hospitalized ❑ Yes ❑ No

Have you had any surgery? (please include all surgery)

1. Type _____ Date _____ Doctor _____
2. Type _____ Date _____ Doctor _____
3. Type _____ Date _____ Doctor _____
4. Type _____ Date _____ Doctor _____

Have you ever had x-rays taken? (if yes) When: _____ Where: _____

Area of body: _____

**Please list the top three stresses in each category:**

| PHYSICAL STRESS (falls, accidents, work postures, etc.) | CHEMICAL STRESS (smoke, unhealthy foods, missed meals, don't drink enough water, drugs, etc.) | MENTAL/EMOTIONAL STRESS (work, relationships, finances, self-esteem, etc.) |
|---|---|---|
| a. _____ | a. _____ | a. _____ |
| b. _____ | b. _____ | b. _____ |
| c. _____ | c. _____ | c. _____ |

Do you wear orthotics or heel lifts? ❑ Yes ❑ No

On a scale of 1–10 describe your: (1 = very poor 10 = excellent)

| EATING HABITS | EXERCISE HABITS | SLEEP | GENERAL HEALTH | MIND-SET | ENERGY LEVEL |
|---|---|---|---|---|---|
| | | | | | |

**HAVE YOU EVER?**

Bought bottled water? ❑ Yes ❑ No
Belonged to a health club? ❑ Yes ❑ No
Consumed vitamins or supplements? ❑ Yes ❑ No

**IF THERE IS A NEED FOR?**

Dietary changes or nutrients would you like to be informed? ❑ Yes ❑ No
Specific exercises would you like to be informed? ❑ Yes ❑ No
Support in the psychological/mind/body/stress dimension of health would you like to be informed? ❑ Yes ❑ No