WAGNER
CHIROPRACTIC HEALTH + WELLNESS CENTRES
www.wagnerwellnesscentres.com

Dr. Ron Wagner

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

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 ______ / ______ / ______ (D / M / Y) E-mail ____________ Gender ❑ M ❑ F Age ______

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 an 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

____

____

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NAME: ______________________ FILE #: ______________

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	O	F	C
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	O	F	C
Chronic cough	❑	❑	❑
Spitting up phlegm/blood	❑	❑	❑
Chest pain	❑	❑	❑
Difficult breathing	❑	❑	❑

URINARY	O	F	C
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	O	F	C
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	O	F	C
Painful menstruation	❑	❑	❑
Excessive flow	❑	❑	❑
Irregular	❑	❑	❑
Cramps or backache	❑	❑	❑
Abnormal discharge	❑	❑	❑
Passed menopause	❑	❑	❑
Are you pregnant	❑	❑	❑
Birth control pill	❑	❑	❑

NAME: ______________________ FILE #: ____________

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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 ________

Please list family Conditions

Mother ____________ Siblings ____________

Father ____________ ____________

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, missed meals, don't drink enough water, unhealthy foods, drugs, marijuana, CBD, E-Cigarettes (Vape) 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

NAME: ______________________ FILE #: ______________

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NAME:		
COMPLAINTS	PRIMARY	SECONDARY OR NEW
HISTORY OF CONDITION - ONSET - LOCATION - PROGRESSION - PRIOR OCC. - WORSE - INTERFERENCE - WORK - FAMILY		
PAIN - CHARACTER - RADIATION - FREQUENCY - DURATION - ASSOCIATION - 1 Z 10 LIFESTYLE		
AGGRAVATING FACTORS		
RELIEVING FACTORS		

POSTURE, SYMPTOM & SUBLUXATION AREAS

1 2 3 4 5 6 7 1 2 3 4 5 6 7 8 9 10 11 12 1 2 3 4 5

FILE #

	L	R								
COMPARATIVE EXAM										
DATE										
Energy										
Sleep										
Immune Function										
Grip										
Cervical										
Flex 60˚										
Ext 50˚										
RR 80˚										
LR 80˚										
RLF 40˚										
LLF 40˚										
Kemps										
Doorbell										
T-L										
Flex 90˚										
Ext 30˚										
RR 30˚										
LR 30˚										
RLF 35˚										
LLF 35˚										
Kemps										
SLR										
Yeomans										
Weight dist.										
Short Leg										

Radiology Report	**PHASE**

NAME: ______________________ FILE #: ____________

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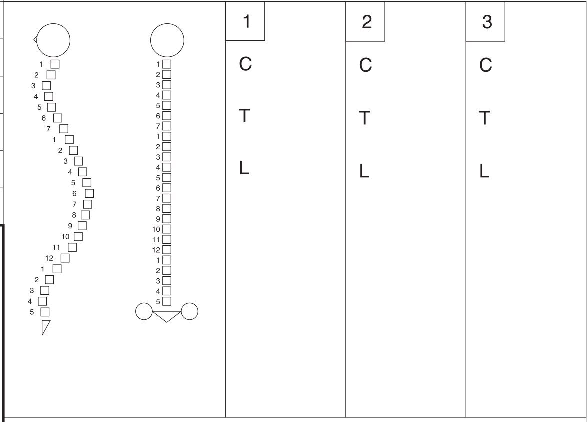
Body Signals
1.
2.
3.
4.
5.
GOAL:

DIAGNOSIS:	TX FREQUENCY:

CONSENT TO EX/TX



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