WAGNER
Chiropractic
A Center For Healing

2775 S. Bay Street
Eustis, FL 32726

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Health Assessment

Patient Name: ______________________________ Date: ____________________

ENERGY How would you rank your energy levels over the past 30 days?
(Low) 1 2 3 4 5 6 7 8 9 10 (High)

CRAVINGS How would you rank your food cravings over the past 30 days?
(Low) 1 2 3 4 5 6 7 8 9 10 (High)

Time of day they occur ________________

SLEEP How would you rank your sleep patterns over the past 30 days?
(Poor) 1 2 3 4 5 6 7 8 9 10 (Excellent)

WEIGHT How happy are you with your body composition over the past 30 days?
(Unhappy) 1 2 3 4 5 6 7 8 9 10 (Very Happy)

STRESS How would you rank your stress level over the past 30 days?
(No Stress) 1 2 3 4 5 6 7 8 9 10 (Stressed)

COGNITION How is your memory/brain function over the past 30 days?
(Poor) 1 2 3 4 5 6 7 8 9 10 (Excellent)

BLOOD PRESSURE How controlled is your blood pressure over the past 30 days?
(Poor) 1 2 3 4 5 6 7 8 9 10 (Excellent)

SEX LIFE How happy are you with your sex life (satisfaction/performance) over the past 30 days?
(Unhappy) 1 2 3 4 5 6 7 8 9 10 (Very Happy)

TOTAL SCORE ____________

Doctor Notes: