***Blackwood Health Center***

Name Date / /

Home Address

City State Zip Email

Birth Date / / Sex M F Height Weight

Home Phone Work Phone Cell Spouse’s Name

What is your major health concern?
When did this problem first begin?
Are you currently in pain or having symptoms? Yes No **None 1 2 3 4 5 6 7 8 9 10 severe**

How long have you been in pain? Days Weeks Months Years
What makes it better? What makes it worse?
Have you ever had this problem in the past? Yes No How many times?

Does the problem affect your daily activities at work? Yes No Home? Yes No

Other health concerns

Current medications, dosage and type

How many times have you been treated with Antibiotics?

When was the last time? For what condition?
Current nutritional supplements and herbal products brand and amounts taken

Do you have any allergies, Seasonal? Food? Etc.

Have you had any X-rays in the past 2 years? Yes No If yes, what for?

Have you ever suffered from or been diagnosed with any of the following? (Circle Y or N)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Broken Bones | Y N | Osteoarthritis | Y N | Gall Stones | Y N |
| Circulatory Problems | Y N | Pacemaker | Y N | Head Injury | Y N |
| Rheumatoid Arthritis | Y N | Strokes | Y N | Anxiety | Y N |
| Seizures/Convulsions | Y N | Epilepsy | Y N | Eating Disorder | Y N |
| Congenital Disease | Y N | Cancer | Y N | Coughing Blood | Y N |
| Excessive Bleeding | Y N | Ulcers | Y N | Diabetes-Type 1 | Y N |
| High Blood Pressure | Y N | Low Blood Pressure | Y N | Diabetes-Type 2 | Y N |
| Depression | Y N | Low Thyroid | Y N | High Thyroid | Y N |

On the diagram below, please indicate where the pain is and use the letters to indicate the type of pain.

Back

Front

|  |  |
| --- | --- |
| A | Aching |
| B | Burning |
| C | Cramping |
| D | Dull Throbbing |
| E | Electrical Shock |
| J | Joint |
| M | Muscle |
| N | Numbness |
| S | Sharp |
| T | Tingling |




*Lifestyle Profile*

Do you smoke? Yes No If yes, how much and for how long?

Do you drink alcohol? Yes No If yes, how much and how often?

How many times per week do you exercise? What type? How many hours do you sleep per night? Do you wake during the night? Yes No

Do you have difficulty getting to sleep? Yes No Do you feel rested in the morning? Yes No
On a scale of 1(low) – 10 (high) what is your energy level like in the
Morning Afternoon Evening

Do you suffer from mood swings? Yes No Do you suffer from depression? Yes No

Do you have children?

# I clearly understand and agree that all services rendered to me or my dependent is charged directly to me and that I am personally responsible for payment.

**Signature Date**

***Consent to treat a minor***

I herby Authorize: Dr. Lee Blackwood DC and whomever he may designate as assistants to administer chiropractic care for my Son / Daughter.

Name of child Date Signed
(Parent or Guardian)