Blackwood Health Center

Name_____Date____/____/____

Home Address_____

City_____State_____Zip_____Email_____

Birth Date____/_____/_____Sex M ___F ____Height_____Weight_____

Cell Phone: _____ 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_____

_____

Do you Currently take supplements Y N

Would you like to review them for optimal outcomes Y N

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?_____

_____

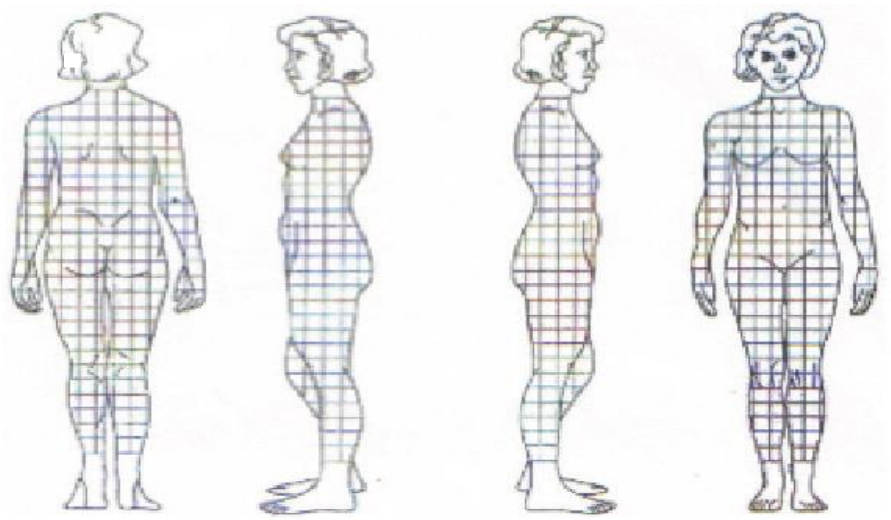
When was the last tine you took antibiotics? _____Type?_____

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.

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? _____

Blackwood Health Center is a cash office, and we do not participate in any insurance plans. This Includes Medicare.

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)