Camilla Moore, DC, ART, SFMA
Benjamin Robinson, DC
Lifestyle Medicine Center
148 West River St. Providence, RI 02904
2nd Floor - Suite 1G
(401) 793-7837

Patient Label

HEALTH HISTORY

Name:	**Date:**

Please check area(s) of complaint:	**Right**	**Left**
Hip / Buttock pain		
Leg pain		
Foot pain		
Shoulder pain		
Neck pain		
Mid-back pain		
Low back pain		
Headaches		

Other (please specify):

____

____

	Yes	**No**
Does the pain travel from one site to another?		
Does your pain change with activity?		

Please explain:

____

____

What makes the symptoms worse? (Check all that apply)

Sitting		Looking down		Other (please specify)	
Getting out of a chair		Sneezing			
Getting out of bed		Coughing			
Turning in bed		Having a bowel movement			
Backing up the car					

How does the pain feel? (check all that apply)

Sharp		Numbness		Other (please specify)	
Achy / Dull		Tingling			
Cramping		Weakness			
Burning					

Approximate date pain began:

Gradual onset (without incident)	Sudden onset (with specific incident)

Please explain the accident / injury & how you think it occurred:

____

____

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Patient Label

HEALTH HISTORY CONTINUED

	Yes	No
Have you ever had cancer?		
Does your pain ever awaken you from a sound sleep?		
Are you losing weight now, without trying?		
Are you coughing up blood or noticing it in your stools or urine?		
Have you had any loss of bladder or bowel control?		
Have you lost consciousness or had double vision recently?		
Do you have a pacemaker?		
Do you exercise regularly?		
Have you ever smoked cigarettes?		
If yes, _______________packs/day, smoked for_____________ years		
Are you still smoking?		
Do you drink alcohol?		
If yes, _________________________ number of drinks per week		
Do you have any previous drug or alcohol problems?		

Please list any medications you take:
____
____
____
____
____
____
____

Please list any Allergies you may have	Type of Reaction

Have you ever had any surgeries? _______Yes ________No

If yes, please list surgery & date(s):
____
____
____
____
____
____

Have you ever been hospitalized for any reason (other than childbirth/surgery)? _____Yes _____No
Please specify:
____
____
____
____

Patient Label

Please describe your symptoms using the chart below:

Symptom key:

==== Aching

dddd Stiffening

^^^^ Tightness

cccc Cramping

xxxx Burning

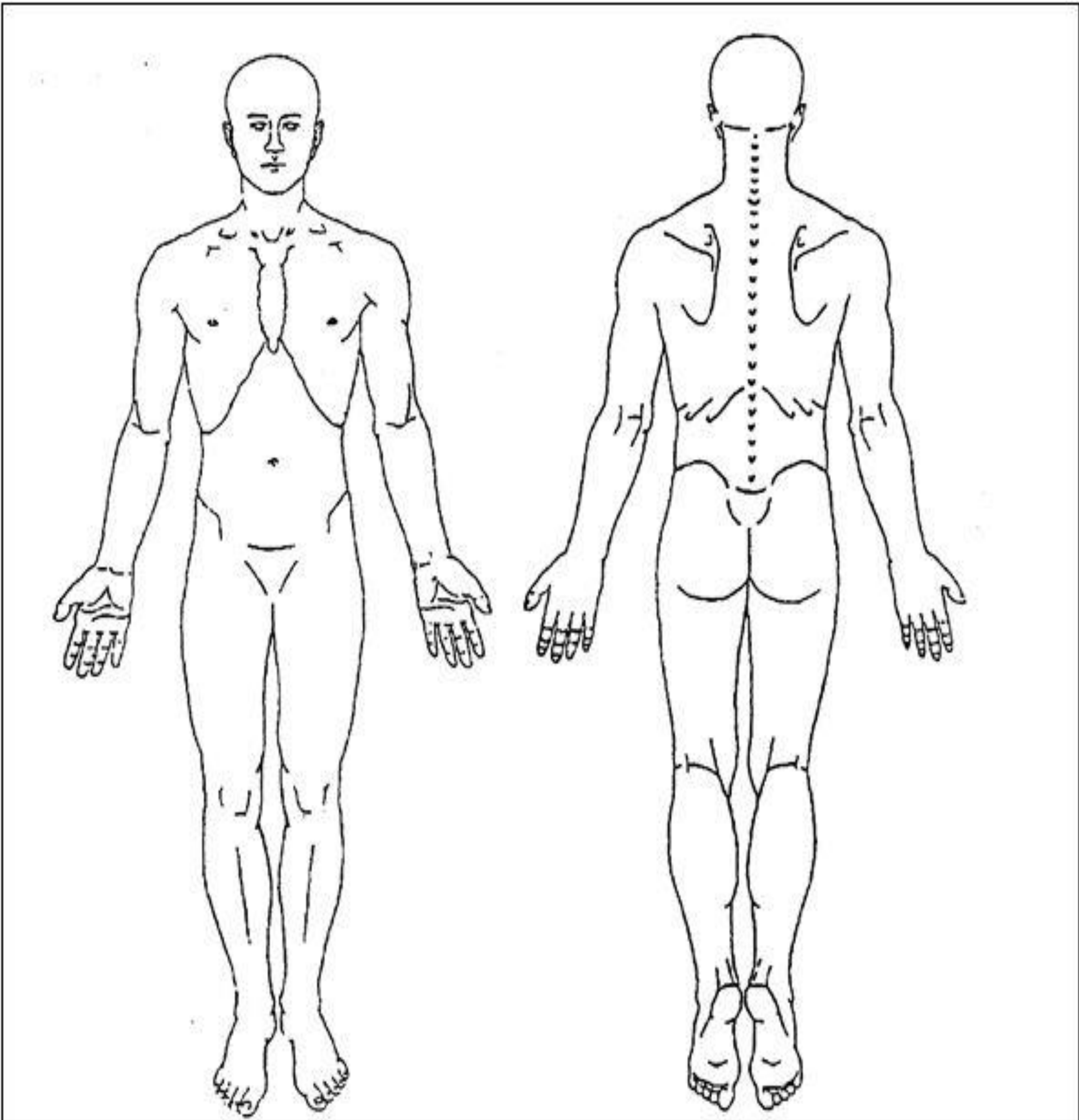
//// Stabbing

0000 Numbness

tttt Tingling

ssss Sensitive

pppp Other



Please add any other comments or descriptions of your condition:

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