



Lifespan Lifestyle Medicine Center
A Lifespan Physician Group Practice
Delivering health with care®

Camilla Moore, DC, ART, SFMA
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	<input type="checkbox"/>	<input type="checkbox"/>	Looking down	<input type="checkbox"/>	Other (please specify) _____ _____ _____
Getting out of a chair	<input type="checkbox"/>		Sneezing	<input type="checkbox"/>	
Getting out of bed	<input type="checkbox"/>		Coughing	<input type="checkbox"/>	
Turning in bed	<input type="checkbox"/>		Having a bowel movement	<input type="checkbox"/>	
Backing up the car	<input type="checkbox"/>				

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

Sharp	<input type="checkbox"/>	<input type="checkbox"/>	Numbness	<input type="checkbox"/>	Other (please specify) _____ _____ _____
Achy / Dull	<input type="checkbox"/>		Tingling	<input type="checkbox"/>	
Cramping	<input type="checkbox"/>		Weakness	<input type="checkbox"/>	
Burning	<input type="checkbox"/>				

Approximate date pain began:

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

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

Patient Label

HEALTH HISTORY CONTINUED

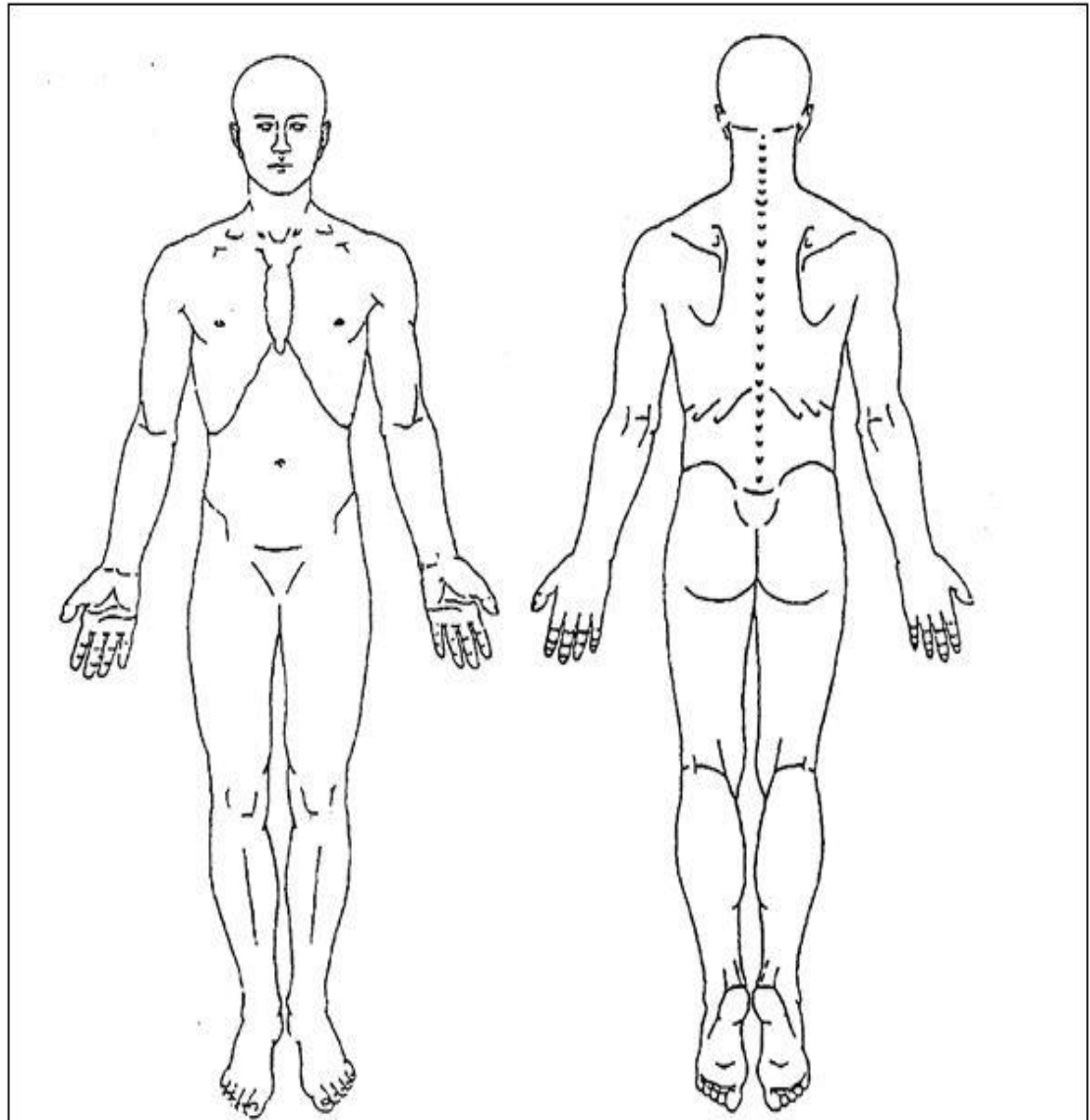
	Yes	No
Have you ever had cancer?		
Does your pain ever awaken you from a sound sleep?		
Are you losing weight now, without trying?		
Are you coughing up blood or noticing it in your stools or urine?		
Have you had any loss of bladder or bowel control?		
Have you lost consciousness or had double vision 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:
