

Age: \_\_\_\_\_  Rt. Handed  Lt. Handed      Sex:  Female  Male  
 Marital Status:  Single  Married  Divorced  Widow(ed)  Other

Reason for visit:

Duration of Symptoms:

Medical problems:	List all previous surgeries:
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**FAMILY MEDICAL HISTORY**

Mother:

Father:

Siblings:

Grandparents:

Children:

Do you use or smoke any mood altering or recreational substances?  Yes  No

Have you ever smoked cigarettes?  Yes  No

- How many packs a day? \_\_\_\_\_

- For how many years? \_\_\_\_\_

If you stopped smoking, when did you stop?  
 \_\_\_\_\_

Do you drink alcoholic beverages  Yes  No

- What type? \_\_\_\_\_

- How much per day / week? \_\_\_\_\_

CT scans:

MRI:

Xrays:

Pain Management:  PT  Chiropractor  Pain Management (ESI / Trigger point inj)  Acupuncture

**Referring Neurologist:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Ph: ( ) \_\_\_\_\_ - \_\_\_\_\_ Fax: ( ) \_\_\_\_\_ - \_\_\_\_\_

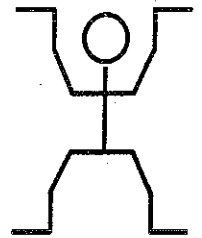
**Referring Doctor:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Ph: ( ) \_\_\_\_\_ - \_\_\_\_\_ Fax: ( ) \_\_\_\_\_ - \_\_\_\_\_



**Patient Health Questionnaire**  
 Southern California Center for Neuroscience & Spine  
 Chapman Medical Center

Addressograph