



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:

**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: ( )\_\_\_\_ - \_\_\_\_\_

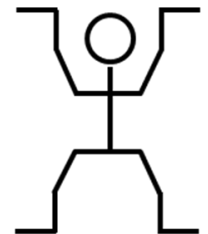
Referring Doctor:

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

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

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

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



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

Addressograph