

**Patient History Form**

Physician's Name: \_\_\_\_\_

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

Street: \_\_\_\_\_, City: \_\_\_\_\_, State: \_\_\_\_\_, Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Sec #: \_\_\_\_\_

PLEASE ANSWER ALL QUESTIONS TO THE BEST OF YOUR ABILITY WITH AS MUCH DETAIL AS POSSIBLE. THIS WILL AID US IN PROVIDING YOU WITH THE BEST CARE POSSIBLE. THANK YOU.

Is your problem:  Neck pain?  Numbness in your arms?  Numbness in your hands?  
 Back pain?  Numbness in your legs?  Numbness in your feet?  
 Other \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ ft \_\_\_\_\_ inches Weight: \_\_\_\_\_ Date your symptoms began: \_\_\_\_\_

Medical history: Have you ever had or do you now have  high blood pressure  diabetes  thyroid disease  kidney disease  
 lung disease  asthma  heart disease  seizure disorder  stomach problems  other \_\_\_\_\_

Surgical history: Have you ever had surgery  gall bladder  hysterectomy  back surgery  carpal tunnel release  
 neck surgery  c-section  hernia repair  open heart  other \_\_\_\_\_

Please list EVERY MEDICATION you take, including prescription medications, over the counter medications, nutritional and herbal supplements \_\_\_\_\_

Are you allergic to any medications  yes  no If yes, please list \_\_\_\_\_

Occupation: \_\_\_\_\_

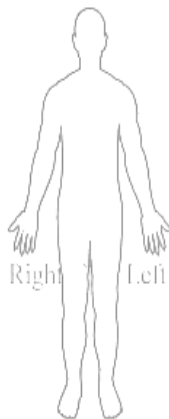
Do you smoke  yes  no If yes, how many packs per day \_\_\_\_\_

Do you consume alcoholic beverages  yes  no If yes, how much do you drink per week \_\_\_\_\_

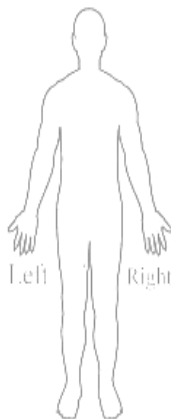
Have you ever been exposed to chemicals  yes  no If yes, which ones \_\_\_\_\_

Please mark the drawings where you have: Numbness xxxxxxxx Pain ||||| Tingling oooooo

Front View



Back View



**Assignment of Benefits and Medical Release**

I the undersigned give my consent to this provider of services to release this patient information form to my insurance carrier as a statement of my medical condition in reference to my illness or injury. I further authorize direct payment for all medical services rendered me by this provider from this date forward to be made directly to Walbridge Physical Medicine and Rehabilitation, PC, Delaware Valley Physical Medicine and Rehabilitation, PC or Eric M. Lipnack, D.O., P.C. This is a direct assignment of benefits under my insurance policy. If my condition is in relationship to a personal injury claim I hereby authorize my attorney to pay the above provider out of any proceeds of settlement or trial or other similar medical payments or insurance, any and all unpaid charges, in accordance with any related charges, made necessary by the injuries I sustained in the accident giving rise to the claim in question, although I recognize that it is my obligation to pay such charges regardless of the disposition of the claim. I further direct my attorney to immediately apply for insurance benefits under any and all existing policies in order to cover the expenses for the above captioned services.

The information provided above is true to the best of my knowledge.

Signature of Patient or legal guardian \_\_\_\_\_

Date: \_\_\_\_\_