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INITIAL INFORMATION FORM

PATIENT INFORMATION

Patient Name: _____ Date: _____
Last First MI

Male/Female Married/Single/Child/Other

Social Security #: _____ Birth Date: _____

Address: _____
Street Apartment #

City State Zip Code

Whom may we thank for referring you to our practice? _____

***THIS OFFICE REQUIRES 24 HOUR NOTICE FOR CANCELLATIONS,
OTHERWISE YOU WILL BE BILLED.***

HEALTH INFORMATION – Please circle all that apply:

AIDS	Fainting/Dizziness	Pacemaker
Allergies	Glaucoma	Pregnancy due _____
- Codeine	Growths/Tumors	Radiation Treatment
- Penicillin	Hay Fever	Respiratory Problems
- Other _____	Headaches/Neck ache	Rheumatic Fever
Anemia	Head Injuries	Rheumatism
Arthritis	Heart Disease	Sinus Problems
Artificial Joints	Heart Murmur	Stomach Disorders
Asthma	Hepatitis/Jaundice	Stroke
Blood Disease	High Blood Pressure	Thyroid Conditions
Cancer	Kidney Disease	Tinnitus
Diabetes	Liver Disease	Tuberculosis
Earaches	Mental Disorders	Ulcers
Epilepsy/Seizures	Mitral Valve Prolapse	Venereal Disease
Excessive Bleeding	Nervous Disorders	Vertigo

Medications:

*Have you been admitted to a hospital or needed emergency care during the past two years? Yes No

*Do you have any health problems that need further clarification? Yes No

If yes, please explain: _____

*Are you now under the care of a physician? Yes No

If yes please explain: _____

*Name of Physician: _____ Phone: _____

Address: _____

General Healthcare Questions

1. What is your chief complaint for seeking this treatment?

2. What is your occupation?

3. Do have stressful situations at home or at work? (If yes, please explain)

4. Do you have pain? _____

5. Where is the pain located?

6. Is the pain constant or does it come and go?

7. Circle the words you would use to describe the pain?

Sharp, Dull, Pulsing, Throbbing, Stabbing, Pinching, Pulling, Hot, Burning, Itchy, Achy, Heavy, Tiring, Annoying, Unbearable, Tight, Numb, Cold, Nagging

8. Is the pain radiating? How far?

9. Has the pain increased, decreased or stayed the same since its onset?

10. Is there a position that makes your symptoms better or worse?

11. Is there a time of day in which your symptoms are better/worse?

12. Does heat or cold make your symptoms better or worse?

13. Describe your diet (type of foods, amount of water, how many meals/day, etc..)

14. Do you take any Vitamins/supplements?

15. Do you have any headaches? (If so, describe how often, location and feeling)

16. Have you seen any other healthcare practitioners for this condition? (If so, what type and what was the result)

To the best of my knowledge, all of the proceeding answers and information provided are true and correct. If I ever have any change in my health, I will inform Jason H. Wallman at the next appointment without fail.

Signature of patient, parent, or guardian

Date: _____



CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All services must be paid for in full upon each treatment visit. As a courtesy to our patients, we accept cash, checks, debit cards, and all major credit cards except Discover.

Patients who carry medical insurance understand that all medical services furnished are charged directly to the patient and that he or she is personally responsible for payment of all medical services. It is also the patient's responsibility to know the guidelines of their particular insurance. This office will help prepare the patient's insurance forms or assist in sending follow up information. However, this medical office does not accept payment from insurance companies, please understand also that we DO NOT PARTICIPATE IN ANY INSURANCE PROGRAM AND WE DO NOT PARTICIPATE IN MEDICARE, I also grant permission for the release of my records should my insurance require them.

I understand that there is a fee charged for all broken or cancelled appointments that are made without 24-hour notice.

In consideration for the professional services rendered to me, or at my request, by Jason H. Wallman, MS, PT, LA c., I agree to pay therefore the reasonable value of said services to Jason H. Wallman, MS, PT, LA c., or his assignee, at the time said services are rendered. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit were instituted hereunder.

I grant permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment, and agree to their content.

_____ Date: _____ Relationship to Patient:
Signature of patient, parent or guardian