Optimal Fit PT, L.L.C.
Susan Laughlin, MPT MA Lic # 10233

PATIENT INFORMATION

Date of Injury:_____ Diagnosis:_____ Copay: $_____

Last Name: _____ First Name: _____
Date of Birth: _____ Sex: M / F
Addresss:_____
Phone #: _____ Cell #: _____
E-Mail: _____

Referring physician: _____
Primary Care Physician: _____

PRIMARY INSURANCE
Insurance Carrier: _____
Member ID#: _____ Group #: _____
Subscriber Name: _____ Subscriber DOB: _____
Relationship to patient (self/spouse/child): _____

SECONDARY INSURANCE
Insurance Carrier: _____
Member ID#: _____ Group #: _____
Subscriber Name: _____ Subscriber DOB: _____
Relationship to patient (self/spouse/child): _____

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History of Present Injury

What brings you to Physical Therapy?

_____

How long have you had this condition? _____
Have you had PT for this before? _____
When? _____ Did it help? _____
What treatments have you already received? _____
Have you had this problem before? _____
Please list or supply a list of all medications you are currently taking:

_____

Past Medical History

Past surgeries: _____
Do you have a history of falls? _____

Check if you have ad any of the following conditions:
Cancer _____
Heart Disease _____
Arthritis/ Gout _____
High Blood Pressure _____
Diabetes _____
Stroke _____
Kidney/Bladder _____
Respiratory Disease _____
Pneumonia / Emphysema _____
Asthma _____
Hernia _____
Thyroid Disorder _____
Other _____
Are you pregnant? _____
Allergies _____