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# MCMEEN PHYSICAL THERAPY CLINIC

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

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

Age Today: \_\_\_\_\_ Diagnosis Code \_\_\_\_\_

Patient SS # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

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

Referring MD: \_\_\_\_\_ Family MD: \_\_\_\_\_

Referring Source: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_

(Please Initial If Medicare Is Primary \_\_\_\_\_)

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

Insured DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Insured SS #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Insured Employer: \_\_\_\_\_

Injury due to an accident?  Yes  No

Have you seen a doctor?  Yes  No Date seen by doctor: \_\_\_\_/\_\_\_\_/\_\_\_\_

Workman's comp/disability insurance:  Yes  No

Home Health:  Yes  No

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## SUBJECTIVE

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Date of Injury: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of Surgery \_\_\_\_/\_\_\_\_/\_\_\_\_

Area Being Treated: \_\_\_\_\_

Major Complaints: How Did It Start?...etc.

Prior history?  Yes  No

Previous Treatment Area: \_\_\_\_\_

Other Medical Problems/conditions: \_\_\_\_\_

Pacemaker/defibrillator?  Yes  No

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## OBJECTIVE

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## GENERAL COMMENTS: