



Physical Therapy ▲ Sports Medicine

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MEDICAL HISTORY

Date: _____
 Patient : _____ Sex: _____ Height: _____
 Weight: _____ Activity level _____
 Work Status: _____ Employer: _____
 Legal action: _____

Past Medical History: Do you have any history of the following? Please explain any **yes** answer

	Yes	No	
Allergies	___	___	_____
Lung disorders/Asthma	___	___	_____
Past injuries / Fractures	___	___	_____
Arthritis	___	___	_____
Pregnant (current)	___	___	_____
Cancer	___	___	_____
TIA/Stroke	___	___	_____
Heart problems	___	___	_____
Circulatory/Sensory changes	___	___	_____
Diabetes	___	___	_____
Blood disorders	___	___	_____
Hypertension	___	___	_____
Bowel/bladder difficulty	___	___	_____
Epilepsy	___	___	_____
Neurological disease	___	___	_____
Fibromyalgia	___	___	_____
Spinal Problems	___	___	_____
Previous Surgeries	___	___	_____
Other	___	___	_____
Do you smoke?	___	___	Amount _____ Alcohol _____

Current Medical History

Date of onset: _____ Diagnosis: _____

Surgery: _____ Date: _____ Procedure: _____

Pain scale from 0-10 (no pain to severe): _____ Aggravating Activities: _____

Symptoms improved by: _____

Diagnostic tests: (x-rays, MRI,etc) _____

Previous treatment: _____

Medications: _____

Goals: _____

Is there any reason, physical or otherwise, why you should not participate in a physical therapy program? _____