

General Medical Form (continued)

At the present time, would you rate your overall general health as:  
\_\_\_excellent \_\_\_good \_\_\_fair or \_\_\_poor?

Please circle all conditions that you have, or have had in the past.

**Musculoskeletal**

Osteoarthritis  
Rheumatoid Arthritis  
Lupus/ SLE  
Fibromyalgia  
Osteoporosis  
Headaches/ Migraines  
Bulging Disc  
Leg Cramps/ Restless Legs  
Jaw Pain/ TMJ  
History of Falling  
Use of cane or walker  
Gout  
Other: \_\_\_\_\_

**Circulation/ Respiratory**

Heart Attack  
Heart Surgery  
Heart Arrhythmia  
Pacemaker  
High Cholesterol  
Blood Clots/ Phlebitis  
Anemia  
High Blood Pressure  
Asthma/ SOB  
COPD  
Other: \_\_\_\_\_

**Endocrine/Digestion**

Diabetes  
Kidney Dysfunction  
Irritable Bowel  
Bladder Dysfunction  
Liver Dysfunction  
Thyroid Dysfunction  
Hernia  
Other: \_\_\_\_\_

**Nervous System**

Stroke/ TIA  
Polio  
Parkinson's disease  
Multiple Sclerosis  
Epilepsy/ Seizures  
Concussion/ TBI  
Numbness or Tingling  
Other: \_\_\_\_\_

**Skin**

Skin Allergies/ rashes  
Eczema  
Psoriasis  
Other: \_\_\_\_\_

**Infectious Disease**

TB  
Hepatitis  
Influenza  
Shingles  
Other: \_\_\_\_\_

**Psychological**

Depression  
Anxiety disorder  
Bipolar disorder  
Schizophrenia  
Obsessive-compulsive disorder  
Other: \_\_\_\_\_

**Cancer**

Type of Cancer \_\_\_\_\_  
Date of Diagnosis \_\_\_\_\_  
Treatments \_\_\_\_\_

Are you currently pregnant? Yes No  
Do you smoke? Yes No

**Patient's signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**I have reviewed any contraindications and their rehabilitation protocol with the named patient or the appropriate caregiver prior to initiating evaluation and treatment. Therapist's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_