514 N 85th St.
Seattle, WA 98103
(206)706.7500
www.realrehab.com

Real Rehab Patient Information

Where did you hear about Real Rehab? ______________________________

Name (Last, First, Middle, nickname) ______________________________

Home Address : ______________________________

City ____________ **State** ________ **Zip Code** __________

Home Phone : (__) ____________ **Other Phone** (Work/Cell) : (__) ____________

SSN: ____________ **Email** : ______________________________

Would you like to receive informational newsletters via email? **Yes** / **No**
Email addresses will not be sold or disclosed under any circumstances, unless directed by patient.

Sex: Male / **F**emale (circle one)

Birthdate (MM/DD/YYYY) ____________

Employer: ______________________ **Employer Phone:**(____)________________

Employer Address: ______________________________

Emergency Contact

Name: ______________________ Relationship:______________________

Phone: (____)______________________

Refering Physician Name: ______________________ **Phone**: (____)________________

Primary Care Physician (If different than above) Name: ______________________

Phone : (____)________________

Nature of Injury:

____

____

____

Date of injury: ______________________ **Claim #**: ______________________

Work related? Yes / No **Motor Vehicle Accident**? Yes / No

(continued on back)

1. Occupation/tasks: ______________________________

2. Current stress level: High Medium Low (circle one)

3. Current activity level: High Medium Low (circle one)

4. Exercise level: Please describe your *current* and *normal (if different)* recreational, sport and exercise activities and how often you participate each):

____
____
____
____

5.Have you ever been diagnosed with, or suspect that you may have/had any of the following*?

1) Heart problems/disease	yes	no	12) Other Brain injuries/disorders	yes	no
2) High/low blood pressure	yes	no	13) HIV/AIDS	yes	no
3) Respiratory ailments	yes	no	14) Other infectious diseases	yes	no
4) Cancer	yes	no	15) Eating disorder(s)	yes	no
5) Bowel or bladder dysfunction	yes	no	16) Allergies	yes	no
6) Rheumatoid arthritis	yes	no	17) Chemical Dependency	yes	no
7) Other arthritic conditions	yes	no	18) Neurological disorder(s)	yes	no
8) Diabetes	yes	no	19) Orthopedic injuries	yes	no
9) Kidney disease	yes	no	20) Depression	yes	no
10) Seizures	yes	no	21) Any mental illness	yes	no
11) Stroke/CVA	yes	no			

*Please provide details on all "yes" answers to question #5 above:

____
____
____
____
____

Please describe and date any surgeries you have had, hospitalizations or other conditions or injuries you have had, if not already addressed:

____
____
____
____
____

Please list any prescription medications that you are taking, or have taken in the last week:

Please list any over-the-counter medications, vitamins and/or nutritional supplements that you are taking, or have taken in the last week:

By signing below I attest that all of the information that I have provided is true and accurate to the best of my knowledge.

Patient signature: ____ Date: ______________
Parent/Guardian signature: ____________________________________ Date: _____________