



Physical Therapy

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- Exercise Metabolic Test
Resting Metabolic Test
Runner's Clinic / Lab
Injury Screening
Pedal Analysis
Custom Orthoses
Cyclist Clinic / Lab
Exercise Consultation

Specialty Services Intake Questionnaire

Where did you hear about Real Rehab? _____

Name: _____

Date of Birth: _____ Sex: Male Female Height _____ Weight _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

E-mail address: _____

Name of Emergency Contact: _____

Phone number of Emergency Contact: _____

To ensure your safety and assist your therapist, please answer the following important questions as precisely as you can. Your therapist will review this form with you and may require further investigation of the information provided. All of your information will be held in strict confidence in accordance with current HIPAA regulations.

1. Occupation/tasks: _____

2. Sports/Hobbies: _____

3. Exercise level (please describe your current sport, exercise, and recreational activities and how often you participate in each): _____

4. Area of concern (please describe as closely as possible the dysfunction, duration, nature of pain, aggravating activities, easing activities and any other information you think might be pertinent): _____

5. What are your goals for this visit? _____ (continued on back)

HEALTH HISTORY

1. Are you currently under the care of any health care provider ? Yes No
If yes, please state type of provider and nature of condition and treatment:

2. 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 the above questions:

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.

Participant signature: _____ Date: _____
Parent/Guardian signature: _____ Date: _____