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METTLER THERAPY SERVICES
PATIENT HEALTH STATUS

Last: ______________________________ First: ________________________ Age: ____ DOB: ____/____/____ Gender: ○ M ○ F

Address: ____ City: ____________________ State: _____ Zip Code: __________

Cell Ph: (____) ____ - _____ Home Ph: (____) ____ - _____ Work Ph: (____) ____ - ______ Email: ____________________________

Appointment reminders/updates ○ text ○ email If text reminders, please name carrier ○ Verizon ○ AT&T ○ T-Mobile ○ Sprint

Height: _______ Weight: _______ How many falls have you had in the last 12 months? ____ Were you injured after a fall? ○ yes ○ no

How did you hear about us? (Please specify)

○ Family/Friend ______________________ ○ Web Search ______________________ ○ Newspaper ______________________
○ Prev. Patient ______________________ ○ Social Media ______________________ ○ Television ______________________
○ Healthcare Prof. ______________________ ○ Direct Mail ______________________ ○ Radio ______________________
○ Mettler Staff ______________________ ○ Event ______________________ ○ Other ______________________

A. Injury History:

1. Describe the physical problem(s) you are having. From the beginning of your problem(s) until now, place the events in chronological order.

____

____

____

2. What started or set off the problem(s)?

☐ just started suddenly ☐ began gradually ☐ lifting ☐ twisting/bending
☐ fall ☐ injured at work ☐ pulling ☐ injured during sports
☐ injured in auto accident ☐ hit from behind ☐ no apparent cause ☐ other: ________________________

3. Approximate date of original pain/symptoms: ____________________ Is this a work related injury? ○ yes ○ no

4. Physician: _______________ Have you been given a diagnosis for this condition? ○ yes ○ no If yes, what? ____________________

5. How much knowledge do you feel you have about your injury or condition? ○ very little ○ little ○ some ○ much ○ very much

6. Have you had any of these diagnostic tests (check all that apply)?

☐ MRI (magnetic resonance imaging) ☐ electromyogram (EMG) ☐ injections
☐ CT (computed tomography) scan ☐ diagnostic x-rays ☐ other ____________________

7. Please indicate the approximate date(s) of your previous treatments/tests, including the name of clinician, what treatments/tests were done, and the results, if known.

Date(s)	Clinicians(s)	Test(s)	Results(s)

8. Please indicate the number of times you have had any of the following treatments for this problem:

___ electrical stimulation ___ traction ___ cold/hot packs ___ massage
___ manipulation ___ strength training ___ work hardening ___ iontophoresis
___ aerobic exercise ___ trigger point work ___ aquatic therapy ___ TENS
___ ultrasound ___ myofascial release ___ splinting ___ other ____________

9. Have you had surgery for this problem or related problems? ○ yes ○ no If yes, how many? ___ When? ____________________

10. Are your symptoms constant or do they come and go? ○ constant ○ come and go

11. What activities make the pain worse (check all that apply)?

☐ exercise (during) ☐ exercise (after) ☐ lifting ☐ driving ☐ climbing (stairs)
☐ lying/sleeping ☐ sitting ☐ standing ☐ walking ☐ running
☐ computer work ☐ writing ☐ bending forward ☐ bending backward ☐ other ____________

12. What do you do to control the pain or dysfunction (check all that apply)?

☐ nothing ☐ lie down ☐ sit ☐ stand ☐ walk
☐ splinting ☐ ice/heat ☐ pain pills ☐ muscle relaxants ☐ aspirin/anti-inflammatory
☐ injections for pain ☐ manipulation ☐ physical therapy ☐ other ________________

13. Using the scale below, rate your low pain ____; average daily pain ____; and high pain ____.

No Pain		Mild		Discomforting		Distressing		Horrible		Excruciating
0	1	2	3	4	5	6	7	8	9	10

14. Is your pain worse in the: O morning O afternoon O evening O night O same O varies

B. Lifestyle:

1. Please note your hobbies, sports, or recreation activities that you like to perform: ______________________________
2. Has your condition/injury prevented you from doing these activities? O yes O no If yes, how? ______________________
3. Do you belong to a health club? O yes O no If yes, what is the name of the club? ______________________

C. Medications:

1. Please bring a list of your current medications.

D. Medical History:

1. Please identify any past or current medical condition the therapist should know about: (high blood pressure, cancer, diabetes, etc.)

____

2. Are you allergic to Latex? O yes O no
3. List any operations you've had: ______________________________

E. Expectations/Goals:

1. Realizing that you are visiting this office for diagnosis and treatment of your problem(s), do you have an opinion about what should be done to correct your present condition? O yes O no

   If yes, please explain ______________________________

2. By the time you have completed your therapy here, how much improvement do you realistically expect to attain?

   O less than 20% improvement O 20–39% improvement O 40–59% improvement
   O 60–79% improvement O 80–90% improvement O 90–100% improvement

3. Please list the three main goals or outcomes you hope to attain as a result of your physical therapy?

   a. ______________________________
   b. ______________________________
   c. ______________________________

By presenting yourself for a consultation, you are consenting to the diagnostic procedure/care provided by the attending therapist.

Patient Signature: ______________________________ Date: ____/____/____
(Signature of parent or guardian if under 18 years old)

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE.

Liability Insurance:

O Work-related O Auto Accident O Other Accident/Injury Date: _____/_____/_____

Insurance Carrier Name: ______________________________

Carrier Billing Address: ______________________ City: ____________ State: ____ Zip: ________

Claim #: ______________ Adjuster Name: ______________ Adjuster Phone: (_____) _____ - ______

If worker's compensation injury, please list company responsible for claims:

Employer: ______________ Supervisor: ______________ Phone: (_____) _____ - ______

Employer Address: ______________________ City: ____________ State: ____ Zip: ________