

**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 \_\_\_\_\_  
 Would you like to be on our email list? yes no

**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:  morning  afternoon  evening  night  same  varies

### B. Lifestyle:

- Please note your hobbies, sports, or recreation activities that you like to perform: \_\_\_\_\_
- Has your condition/injury prevented you from doing these activities?  yes  no If yes, how? \_\_\_\_\_
- Do you belong to a health club?  yes  no If yes, what is the name of the club? \_\_\_\_\_

### C. Medications:

- Please bring a list of your current medications.

### D. Medical History:

- 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?  yes  no

3. List any operations you've had: \_\_\_\_\_

### E. Expectations/Goals:

- 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?  yes  no

If yes, please explain \_\_\_\_\_

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

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

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

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**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:** \_\_\_\_\_

Work-related    Auto Accident    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: \_\_\_\_\_