METTLER THERAPY SERVICES
PATIENT CONSULTATION

Last: ________________________________ First: ______________________________ Age: ____ Date of Birth: _____/_____/_____

A. Injury History:

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

____
____
____
____
____

1. 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: _______________
2. Approximate date of original pain/symptoms: _____________________ Is this a work related injury? ○ yes ○ no
3. Does any member of your family have the same or similar problem(s)? ○ yes ○ no
   If yes, explain: ____
4. D\ngMJUb. SSSSSSSSSSSSSSSSS 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) ☐ arthrogram or sonogram
   ☐ CT (computed tomography) scan ☐ diagnostic x-rays ☐ discogram
   ☐ myelogram (x-ray with dye injection) ☐ injections ☐ 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	Test	Clinician	Result

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 ☐ asprin/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

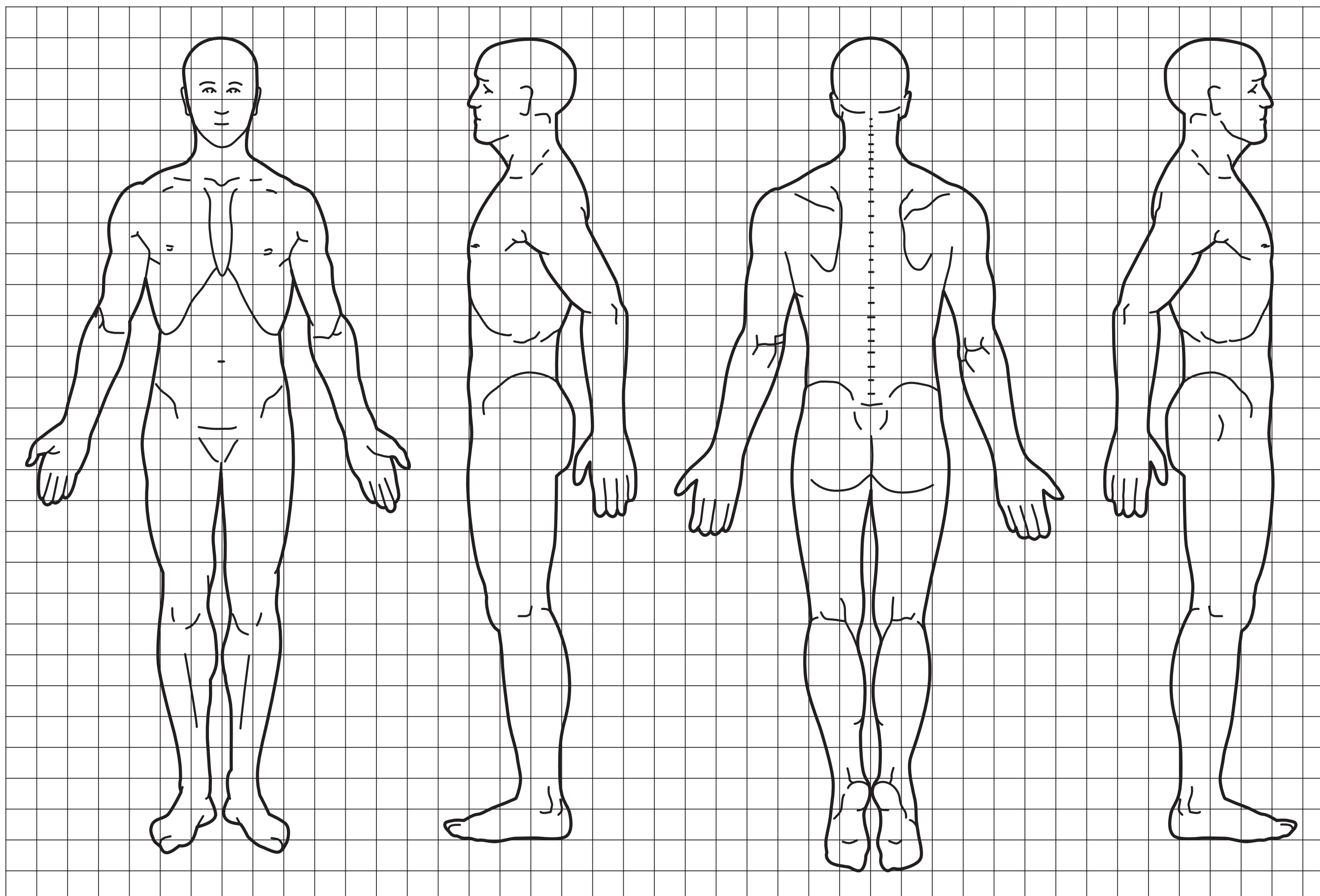
0 1 2 3 4 5 6 7 8 9 10

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

15. Check the words that best describe your feelings of discomfort (check all that apply):

☐ sharp/stabbing - S ☐ dull - D ☐ tingling - T ☐ pins & needles - N
☐ aching - A ☐ heavy pressure - H ☐ burning - B ☐ radiating - R
☐ numb - U ☐ pain - P ☐ moderate pain - M ☐ severe pain - V

16. Use the appropriate letters (listed above) to mark the areas on the diagram where you feel these symptoms.



B. Lifestyle:

1. Please note any hobbies, sports, or recreation activities you like to perform:

____

2. Has your current condition/injury prevented you from doing these activities? ○ yes ○ no

   If yes, how? ____

C. Medications:

1. Please list all medications currently being taken:

Medication	For	Began Taking	Comments

D. Medical History:

1. Please identify any past or current medical condition the therapist should know about:

____

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

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