METTLER THERAPY SERVICES
PATIENT HEALTH STATUS

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\ngJ]Ub. 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 ____.

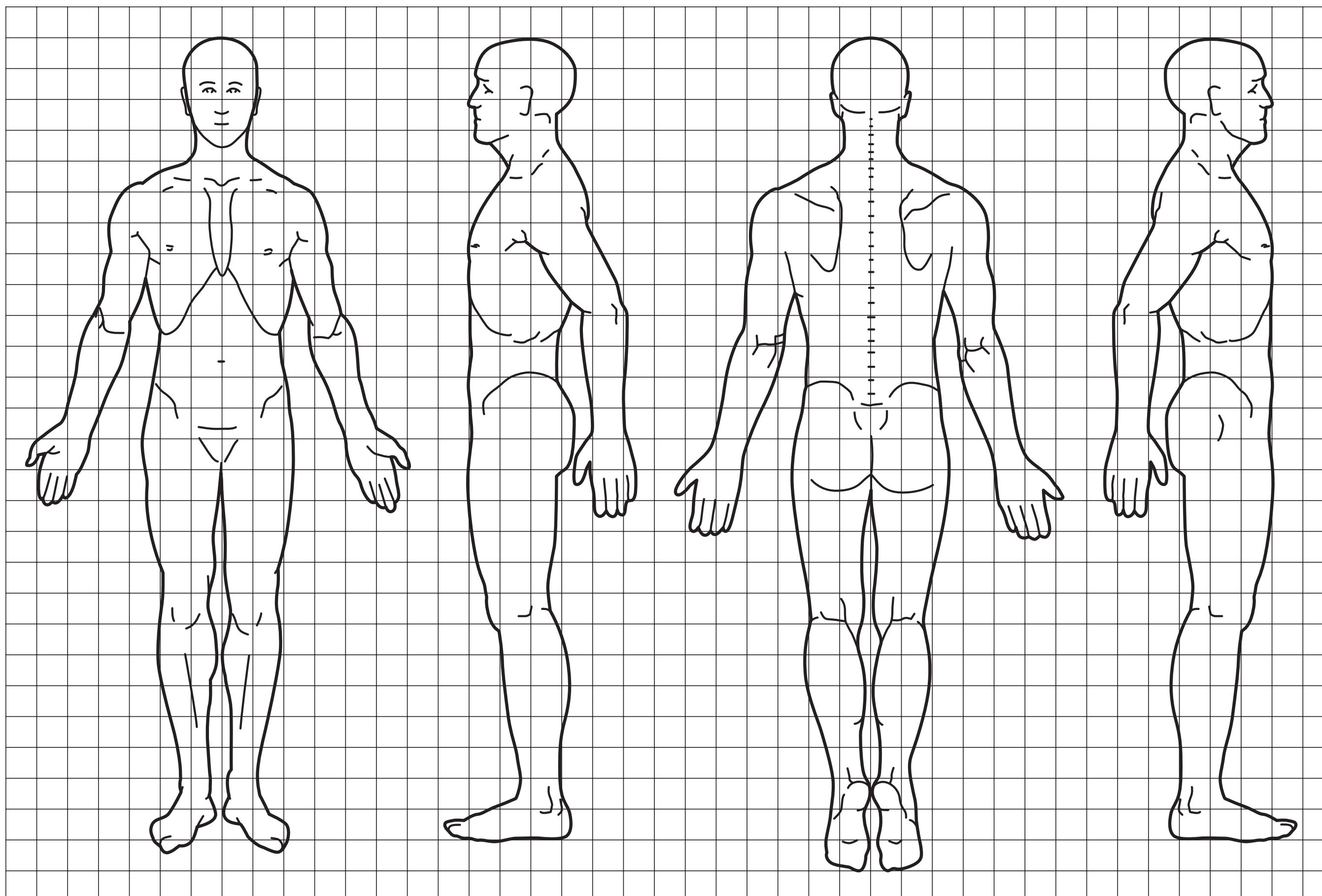
No Pain		Mild		Discomforting		Distressing		Horrible		Excruciating
0	1	2	3	4	5	6	7	8	9	10

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 - I ☐ 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:

____
____
____
____
____

2. Are you allergic to Latex? ○ yes ○ no

3. Could you possibly be pregnant? ○ yes ○ no

4. Have you ever been told you have:

Condition	Date Diagnosed	Comments
Cancer		
Diabetes		
Heart Disease		
High Blood Pressure		
Stroke		
Kidney disease/stones		
Allergies		
Breathing difficulties (asthma, emphysema)		
Ulcers/stomach problems		
Depression		
Chemical dependency (alcohol, drugs)		
Arthritis		
Epilepsy		
Neurological disease (MS, ALS)		
Fibromyalgia		
Headaches		
Osteoporosis/Osteopenia		
Urinary Tract Infection		
Thyroid problems		
Other ______________________________		

5. Have you had:
   a. Any illnesses in the past three weeks (cold, flu, infections)? ○ yes ○ no
   b. Any changes in or difficulties with bowel or bladder? ○ yes ○ no
   c. Any lumps or thickening of skin/muscle anywhere on your body? ○ yes ○ no
   d. Unexplained weight loss/gain in past month? ○ yes ○ no
   e. Do you smoke/chew tobacco? ○ yes ○ no
      If yes, ___ packs/day for ___ years, or ____
   f. How much alcohol do you drink in one week? ____________________________________
   g. Do you use recreational drugs (marijuana, methamphetamines, cocaine)? ○ yes ○ no
   h. Do you have a pacemaker, transplanted organ, joint replacements, or metal implants? ○ yes ○ no
      If yes, please specify ____

6. Fall history (check all that apply):
   - ☐ I have had no falls.
   - ☐ I have just started to lose my balance.
   - ☐ I fall occasionally (once a year).
   - ☐ I fall frequently (more than two times in the past six months).
   - ☐ Certain things make me cautious (curbs, stairs, ice, getting in/out of tub).

7. List any operations you've had:

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E. Employment:

1. Employer: ________________________ Occupation/Job Title: ________________________
2. What is your present employment status? (select one)
   - O Employed and working full duty
   - O Employed and working light duty
   - O Employed but off work
   - O Receiving disability
   - O Unemployed
   - O Student
   - O Retired
3. Does your job involve (check all that apply):
   - ☐ Prolonged sitting (desk, computer, driving)
   - ☐ Prolonged standing (sales clerk, server)
   - ☐ Prolonged walking (delivery service, server)
   - ☐ Use of large or small equipment (phone, forklift, computer, cash register)
   - ☐ Lifting, bending, twisting, climbing, turning
   - ☐ Other (please describe): ________________________

F. 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–, - % improvement O 90–100% improvement
3. Please list the 3 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 procedures/care provided by the attending therapist.

Patient Signature: ________________________ Date: _____/_____/_____

(Signature of parent or guardian if under 18 years old)

Office use only: Resting HR: _______ BP: _____/_____ Extremity: _______ Position: _______