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Physician: _____
Physician's fax: _____
Today's date: ____/____/____

METTLER THERAPY SERVICES PHYSICAL THERAPY CONSULTATION

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

A. Injury History:

Describe the physical problem(s) you are having in your own words. From the beginning of your problem(s) to the present time, try to place the events in chronological order. _____

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

- | | | | |
|---------------------------------------------------|------------------------------------------|--------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> just started suddenly | <input type="checkbox"/> began gradually | <input type="checkbox"/> lifting | <input type="checkbox"/> twisting/bending |
| <input type="checkbox"/> fall | <input type="checkbox"/> injured at work | <input type="checkbox"/> pulling | <input type="checkbox"/> injured during sports |
| <input type="checkbox"/> injured in auto accident | <input type="checkbox"/> hit from behind | <input type="checkbox"/> no apparent cause | <input type="checkbox"/> 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. Have you been given a diagnosis for this condition? yes no If yes, what? _____

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

- | | | |
|---------------------------------------------------------------|-----------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> MRI (magnetic resonance imaging) | <input type="checkbox"/> electromyogram (EMG) | <input type="checkbox"/> arthrogram or sonogram |
| <input type="checkbox"/> CT (computed tomography) scan | <input type="checkbox"/> diagnostic x-rays | <input type="checkbox"/> discogram |
| <input type="checkbox"/> myelogram (x-ray with dye injection) | <input type="checkbox"/> injections | <input type="checkbox"/> other _____ |

6. 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)

7. 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 _____ |

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

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

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

- | | | | | |
|--------------------------------------------|-------------------------------------------|------------------------------------------|-------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> exercise (during) | <input type="checkbox"/> exercise (after) | <input type="checkbox"/> lifting | <input type="checkbox"/> driving | <input type="checkbox"/> climbing (stairs) |
| <input type="checkbox"/> lying/sleeping | <input type="checkbox"/> sitting | <input type="checkbox"/> standing | <input type="checkbox"/> walking | <input type="checkbox"/> running |
| <input type="checkbox"/> computer work | <input type="checkbox"/> writing | <input type="checkbox"/> bending forward | <input type="checkbox"/> bending backward | <input type="checkbox"/> other _____ |

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

- | | | | | |
|----------------------------------------------|---------------------------------------|-------------------------------------------|-------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> nothing | <input type="checkbox"/> lie down | <input type="checkbox"/> sit | <input type="checkbox"/> stand | <input type="checkbox"/> walk |
| <input type="checkbox"/> splinting | <input type="checkbox"/> ice/heat | <input type="checkbox"/> pain pills | <input type="checkbox"/> muscle relaxants | <input type="checkbox"/> aspirin/anti-inflammatory |
| <input type="checkbox"/> injections for pain | <input type="checkbox"/> manipulation | <input type="checkbox"/> physical therapy | <input type="checkbox"/> other _____ | |

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

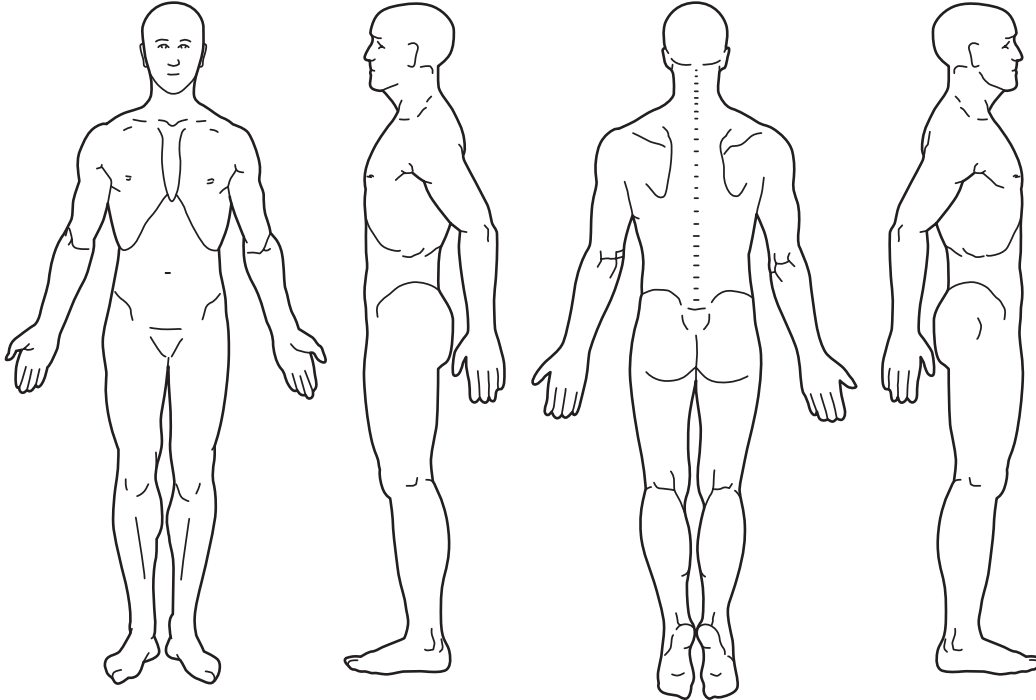
No Pain	Mild	Discomforting	Distressing	Horrible	Excruciating
1	2	3	4	5	6
7	8	9	10		

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

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

- sharp/stabbing - S dull - D tingling - T pins & needles - PN
- aching - A heavy pressure - H burning - B radiating - R
- numb - /// pain - ● moderate pain - ⊗ severe pain - ≡

15. Using the appropriate letters or symbols following each feeling listed above (in question 14), mark the areas on your body where you feel these symptoms. Mark all affected areas. Circle the area where the pain is most intense.



16. How much knowledge do you feel you have about your injury or condition?

- very little little some much very much

B. Medical:

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

2. Please list all medications currently being taken:

Medication	For	Began Taking	Comments

3. Please list any allergies you have: _____

C. Employment:

Employer: _____ Occupation/Job Title: _____

What is your present employment status? (check one)

- Employed and working full duty Employed and working light duty Employed but off work
- Receiving disability Retired Unemployed Full-time student

D. Lifestyle:

1. Please note your hobbies, sports, or recreation activities that you like to perform: _____

2. Has your current condition/injury prevented you from doing these activities? yes no If yes, how? _____

By presenting yourself for a PT/OT consultation at this facility, you are consenting to the diagnostic procedures and care provided by the attending Physical/Occupational Therapist. Patient Signature: _____

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