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

METTLER THERAPY SERVICES NEW PATIENT INFORMATION FORM

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 ____.

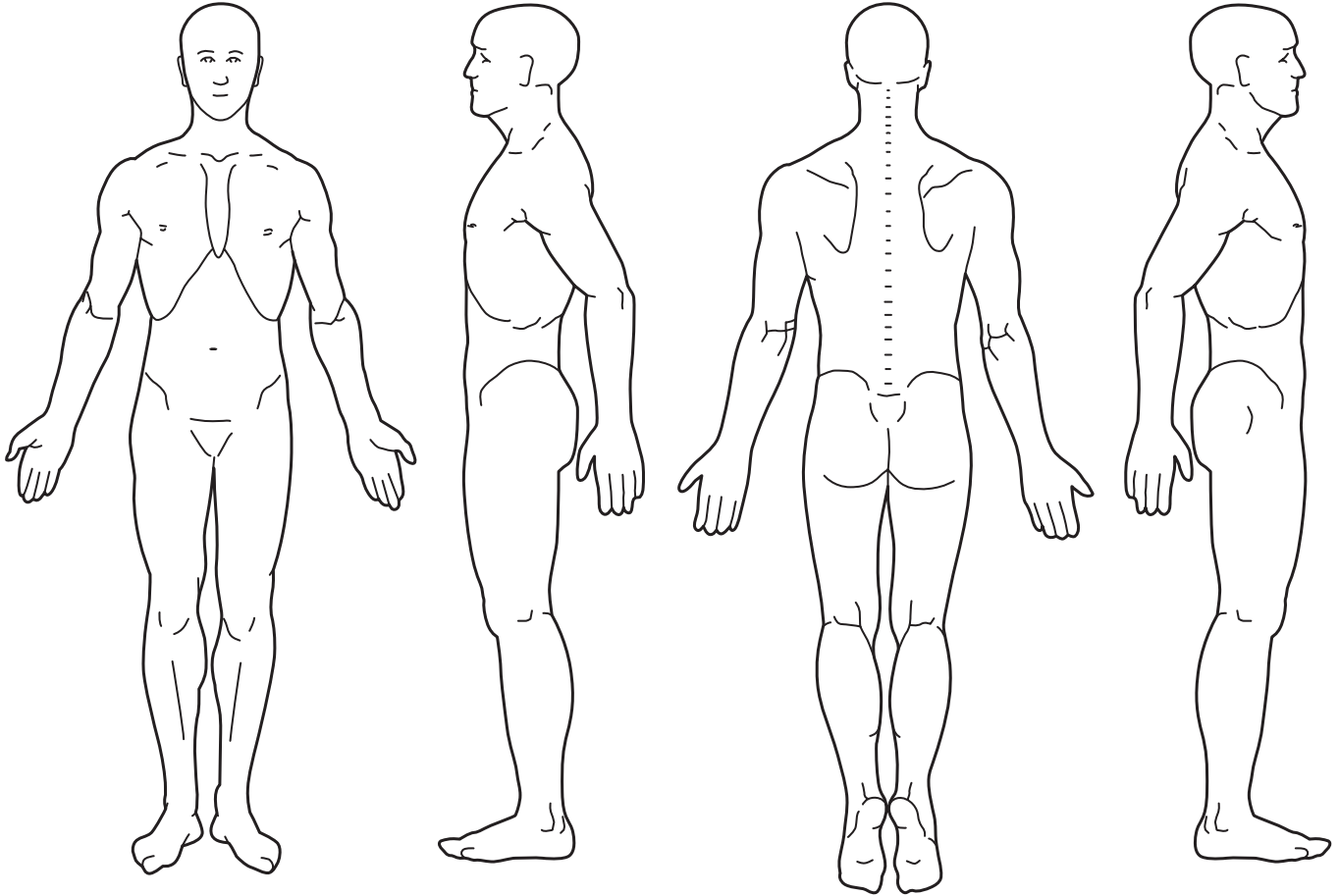
No Pain	Mild	Discomforting	Distressing	Horrible	Excruciating
1	2	3	4	5	6
7	8	9	10		

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):

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> sharp/stabbing - S | <input type="checkbox"/> dull - D | <input type="checkbox"/> tingling - T | <input type="checkbox"/> pins & needles - PN |
| <input type="checkbox"/> aching - A | <input type="checkbox"/> heavy pressure - H | <input type="checkbox"/> burning - B | <input type="checkbox"/> radiating - R |
| <input type="checkbox"/> numb - /// | <input type="checkbox"/> pain - ● | <input type="checkbox"/> moderate pain - ⊗ | <input type="checkbox"/> 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

17. 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? _____

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

- | | | |
|--|---|--|
| <input type="checkbox"/> less than 20% improvement | <input type="checkbox"/> 20–39% improvement | <input type="checkbox"/> 40–59% improvement |
| <input type="checkbox"/> 60–79% improvement | <input type="checkbox"/> 80–90% improvement | <input type="checkbox"/> 90–100% improvement |

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

B. 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?

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

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):

D. Medications:

1. Please list all medications currently being taken:

Medication	For	Began Taking	Comments

E. Medical History:

1. Are you allergic to Latex? yes no
2. Could you possibly be pregnant? yes no
3. Have you ever been told you have:

	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		

4. 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? _____

5. List any operations you've had:

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

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE.

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