integrated massage
by DaleAnn

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Lymphedema Intake Form

Brief Medical History

(completed by patient on intake)

Date: _____

Name: _____ **Date of Birth:** _____

Completed by: ☐ Patient *(listed above)* ☐ Other: _____

Do you currently experience swelling/Lymphedema? *(Please check all that apply)*

☐ right arm ☐ left arm ☐ both arms ☐ breast ☐ right leg ☐ left leg ☐ both legs ☐ head & neck ☐ genital

☐ Other, please explain: _____

Have you been diagnosed with Lymphedema? ☐ Yes ☐ No **If Yes, by whom:** _____

How long have you had swelling/Lymphedema? _____

Was there a trigger event which caused the swelling/Lymphedema?

Please describe briefly how and why your swelling/Lymphedema developed:

Have you had any surgery? ☐ Yes ☐ No

If Yes, list surgeries and dates:

Have you had any lymph nodes removed? ☐ Yes ☐ No **If Yes, how many?** _____

Have you ever received radiation therapy for cancer? ☐ Yes ☐ No

If Yes, list area of radiation and dates here:

Have you had Chemotherapy? ☐ Yes ☐ No **If Yes, how long ago?** _____

Have you had any infections (Cellulities)? ☐ Yes ☐ No **If Yes, how long ago was the last one?** _____

Is there a family history of Lymphedema? ☐ Yes ☐ No

If Yes, please explain:

Do you have pain? ☐ Yes ☐ No

If Yes, please explain:

Any loss of function or mobility? ☐ Yes ☐ No

If Yes, please explain:

Do you have any difficulties with any of the following:

☐ walking ☐ reaching feet and toes ☐ preparing meals ☐ dressing ☐ bathing/showering

☐ Other, please explain: _____

What is your current living situation?

☐ private home/apartment (alone) ☐ nursing home ☐ hospice ☐ home with spouse or companion ☐ assisted living

☐ Other, please explain: _____

Do you currently suffer from (or have you had) any of the following?

☐ Asthma ☐ Bronchitis ☐ Crohn's Disease ☐ Deep Venous Thrombosis (blood clot) ☐ Diabetes

☐ Difficulties Breathing ☐ Diverticulitis ☐ Heart Edema ☐ Hypertension ☐ Hyperthroidism

☐ Infections (Cellulitis) ☐ Irregular Heart Beat ☐ Kidney Failure ☐ Latex Allergy ☐ Malignancy (Cancer)

☐ Recent Abdominal Surgery ☐ Sleep Apnea ☐ Unexplained Pain ☐ Other _____

☐ Other _____ ☐ Other _____ ☐ Other _____

Do you have any other medical problems not listed above? ☐ Yes ☐ No

If Yes, please explain:

Are you allergic to: ☐ Latex ☐ Surgical Tape ☐ Foam Products ☐ Other _____

Are you taking any medication? ☐ Yes ☐ No

If Yes, list medications and amounts here:

At the time you are completing this, are you, or is there a chance you could be pregnant? ☐ Yes ☐ No

PREVIOUS TREATMENTS

Have you had previous treatment for swelling/Lymphedema? ☐ Yes ☐ No

If Yes, check all that apply:

☐ Manual Lymph Drainage (MLD) ☐ Compression Pump ☐ Compression Garments

☐ Compression Bandaging ☐ Flexitouch ☐ Lymphedema Exercise

☐ Low Level Laser ☐ _____ ☐ _____

If Yes, please explain your experience, success or lack of success:

Do you current wear a compression sleeve or stocking? ☐ Yes ☐ No

If Yes, how often do you wear it and how old is it?

Do you currently use compression at night? ☐ Yes ☐ No

If Yes, please explain:

Do you exercise regularly? ☐ Yes ☐ No

If Yes, please explain:

Are you familiar with the National Lymphedema Network? ☐ Yes ☐ No

Are you familiar with the precautions (risk reduction practices) for Lymphedema? ☐ Yes ☐ No

Are you a member of a breast cancer or Lymphedema support group? ☐ Yes ☐ No

If Yes, please explain:

Is there anything else you would like to tell me at this time?