PHOENIX
ONCOLOGY AND
LYMPHEDEMA THERAPY

Evaluation Date: _____

LYMPHEDEMA THERAPY PATIENT INTAKE FORM

All questions contained in this form are strictly confidential and will become part of your medical record.

DEMOGRAPHICS

Name: _____Date of Birth:_____ Age:_____

Phone: _____ Email: _____

Insurance Name_____ ID Number_____

Current Weight: Height: Hand Preference: ☐ Right ☐ Left

To be completed by lymphedema staff

Blood Pressure: ***Heart Rate:*** ***Respiratory Rate:*** ***Pulse Oximetry:***

PHYSICIAN INFORMATION

Referring Physician: _____ Physician's Specialty: _____

Referring Physician Phone #: _____Referring Physician Fax #:_____

Please list all medical providers involved in your healthcare:

Name of Medical Provider	Specialty	Phone Number

SWELLING HISTORY

Currently I am experiencing (please circle):

Swelling	Rash	Weakness Shortness of breath	Open sores that will not heal
Impaired motion	Pain	Numbness / tingling	Heaviness/tightness/fullness
Heaviness/tightness/fullness	Skin changes: dry, discolored, weeping, hard		Other

Which body part is affected?

Date of initial onset of symptoms:

Does anyone in your immediate family have a history of swelling?

THERAPY HISTORY

Have you received ANY outpatient Physical, Speech or Occupational Therapy Services this year?

Are you ***currently*** being seen for outpatient Physical, Speech or Occupational Therapy Services?

Are you ***currently*** receiving home health services including nursing, Physical, Speech, Occupational Therapy Services or home health aide?

Have you had lymphedema therapy before? ☐ Yes ☐ No If yes, where and when?

What treatments have you received?

Manual Lymphatic Drainage	Compression Garments
Compression Bandage Wrapping	Pneumatic Compression Pump
Diuretics	Antibiotics
Kinesio Taping	Other:
Self Drainage	

MEDICAL HISTORY

Do you have any of the following medical conditions?

High Blood Pressure	Diabetes	Renal (Kidney) Dysfunction
Asthma	Congestive Heart Failure	Cardiac Arrhythmia
Arterial Disease	Thyroid Problems	Neuropathy or loss of sensation
Paralysis	GERD (Reflux)	Diverticulitis
Crohn's Disease	Fractures	Scoliosis
Vertigo (Dizziness)	Cancer	Breathing Problems
Heart Problems	Circulation Problems	Deep Vein Thrombosis (Blood Clot)
Aortic Aneurysm	Osteoporosis	Other

Is there a possibility you are pregnant? ☐ Yes ☐ No

Do you have a pacemaker? ☐ Yes ☐ No

SWELLING HISTORY

Do you live in a ☐ House ☐ Apartment/Condo ☐ Mobile Home

Do you live alone? Do you sleep in a bed / chair / other?

How many steps do you have to enter your home?_____ Do you have a railing? ☐ Right ☐ Left ☐ Both

How many steps do you have inside your home?____ Do you have a railing? ☐ Right ☐ Left ☐ Both Do you have help to participate in lymphedema therapy?

Do you require assistance for walking or getting in/out of a chair or bed?

Do you require assistance for bathing or dressing?

Are you currently working? ☐ Yes ☐ No ☐ Retired

SOCIAL HISTORY (CONTINUED) Occupation:

What recreational activities do you do on a regular basis (e.g., walking, swimming, weightlifting, hiking, crafts, sewing)?

How many days a week are you physically active? ☐ 0 ☐ 1-2 ☐ 3-5 ☐ 6-7

Please list **3 important activities** that you are unable to do or that you are having difficulty doing as a result of your swelling:

1. _____

2. _____

3. _____

GOALS

Please list your goals for evaluation and/or treatment for lymphedema therapy:

1. _____

2. _____

3. _____

MEDICATIONS

_____ For what:_____ How often taken:_____

_____ For what:_____ How often taken:_____

_____ For what:_____ How often taken:_____

_____ For what:_____ How often taken:_____

_____ For what:_____ How often taken:_____

_____ For what:_____ How often taken:_____

_____ For what:_____ How often taken:_____

SURGICAL HISTORY

Please list ANY surgeries and dates performed in your lifetime (i.e.: knee surgery, hysterectomy, C-section):

Have you had ANY infections of the skin (i.e.: cellulitis) that required hospitalization and/or antibiotics (oral or IV)? If so, please indicate area of infection and date of episode:

ALLERGIES

Do you have any allergies?: _____ Any allergies to tapes? _____

PAIN

On a scale from 0 (no pain) to 10 (the worst pain you could imagine), what is your pain:

Now:	0	1	2	3	4	5	6	7	8	9	10
Worst:	0	1	2	3	4	5	6	7	8	9	10
Best:	0	1	2	3	4	5	6	7	8	9	10

Where is your pain centered?

Describe your pain (e.g. ache, heavy, sharp, constant, burning)

What increases your pain? _____

What decreases your pain? _____

Is there anything else you would like us to know? _____

CANCER HISTORY

When were you diagnosed?

What type of cancer?

What is the present status of your cancer?

Have you had any of the following? Please list dates:

Mastectomy: ☐ Right ☐ Left ☐ Bilateral	Complete Hysterectomy
Lumpectomy: ☐ Right ☐ Left ☐ Bilateral	Chemotherapy
Lymph Node Dissection: ☐ Right ☐ Left ☐ Bilateral	Radiation Therapy
Breast Reconstruction: ☐ Right ☐ Left ☐ Bilateral	Other:

CONSENT

Can we leave a voice message on your telephone? ☐ Yes ☐ No

Signed: _____ Date: _____