SPORTS REHAB & PROFESSIONAL THERAPY ASSOCIATES, INC. ---LYMPHEDEMA CLINICAL INTAKE FORM

Name:_____ Date:_____

Address:_____ Date of Birth:_____

Referring Doctor:_____ Medicare #:_____ Occupation_____

1. Affected Area – Right Arm Left Arm Right Leg Left Leg Other _____

2. When did your problem begin? _____

3. What was the cause? _____

4. Medical History (please check all that apply)
   - o History of lymphedema
   - o Congestive heart failure
   - o Diabetes
   - o Heart Disease
   - o Hypertension
   - o Kidney disease
   - o Pacemaker
   - o Respiratory problems
   - o Vascular problems
   - o Vein stripping
   - o Cellulitis or other infection
   - o Broken bone
   - o Blood clots
   - o Cancer Did you have : Chemotherapy Radiation Medication
   - o Breast Surgery Did you have: Lumpectomy Mastectomy Axillary/Node Dissection
   - o Other Surgery(ies)_____

5. Have you had previous intervention for your lymphedema?
   - o Yes Where?_____
   - o No

6. Do you wear a compression sleeve /garment?
   - o Yes What type?_____
   - o No

7. Have you ever had open sores on the affected limb?
   - o Yes
   - o No

8. Do you have pain associated with lymphedema?
   - o Yes
   - o No

   Please rate your pain: (no pain) 1 2 3 4 5 6 7 8 9 10 (severe pain)
   Duration of pain --- Constant Intermittent
   What relieves the pain?_____

9. Do you have any functional limitations in your daily activities? Yes No
   --if yes, please list _____

10. Do you exercise regularly?_____