277 Peninsula Farm Rd.
Building 3, Suite "I"
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202-681-1779
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Lymphedema / Oncology Intake Form

Client Demographics

Name:______________________________ Date:____________________

Date of Birth: / / Age: ________Phone Number____________________

Address:____

e-mail: ________________________ Insurance: ____________________

Emergency Contact Name:________________ Phone:____________________

Referred by:____________________Primary Care MD:____________________

Reason for seeking occupational therapy services today:____________________________________

____

Home Environment

1. Occupation Status: ☐ Employed ☐ Medical Leave ☐ Unemployed ☐ Retired
2. How would you rate your health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
3. Do you Exercise currently? ☐Yes ☐ No
4. How many falls have you had in the past 3 months? ☐ 0 ☐ 1-2 ☐ 3+
5. Do you have any of the following devices:
   - ☐Single Point Cane ☐ Walker or Rollator
   - ☐Wheelchair ☐ Raiser Toilet Seat
   - ☐Grab bars ☐ Bed Rail
   - ☐Hand Held Shower Head ☐ Reacher / Grabber
   - ☐Sock Aid ☐ Other: ______________
6. What is your current living situation?
   - ☐Single home w/spouse/companion ☐ Private home - Alone
   - ☐Nursing Home ☐ Assisted Living
   - ☐Hospice ☐ Other: ______________
7. How many steps do you have? ☐ NA ☐ 0-8 steps ☐ 8-13 steps
8. Are there handrails, if yes, which side? ☐ Right- going up ☐ Left- going up ☐ Both

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Medical History

Past Medical History (please check all that apply):

☐Asthma ☐ Bronchitis ☐ Difficulty Breathing
☐Irregular Heart Rhythm ☐ Congestive Heart Failure ☐ Hypertension
☐Heart Attack/Stent/CABG ☐ Pacemaker / Defibrillator ☐ Hyper/Hypothryoid
☐Chronic Kidney Disease ☐ Kidney Failure ☐ Diabetes
☐Infection / Cellulitis ☐ Sleep Apnea ☐ Malignancy / Cancer
☐Crohn's / Ulcerative Colitis ☐ Diverticulitis ☐ Recent Abdominal Surgery
☐Unexplained Pain ☐ Bleeding Disorders or Clots ☐ Latex Allergy
☐Stroke ☐ Seizures ☐ Fibromyalgia
☐Osteoporosis / Osteopenia ☐ Concussion / TBI ☐ Neurological Conditions
☐Arthritis ☐ Depression ☐ Anxiety
☐Hearing Loss ☐ Vision / Eye Conditions ☐ Lymphedema / Lipedema
☐Chronic Venous Insufficiency ☐ Peripheral Artery Disease ☐ Other: ___________________

List Medications

Medication	*Reason*	*Dosage*	*Frequency*

Allergies to any medications?

____

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Surgical History:____

____

____

____

At the time of completing this, could you be pregnant? ☐ NA ☐ YES ☐ NO

Test / Imaging

☐ NA ☐ XRay ☐ CT Scan ☐ Ultrasound / Doppler ☐ MRI

☐ Mammogram ☐ Biopsy ☐ Genetic Testing ☐ Nerve Conduction

History of Present Condition

Location of Pain: ____

Level of Pain (0=no pain, 10= worse pain):

Current: At its best: At its worse:

Pain Description:

☐ Dull ☐ Aching ☐ Intermittent ☐ Chronic

☐ Shooting ☐ To Touch ☐ Consistent ☐ Other:_______________

What makes it worse

☐ Sitting ☐ Walking ☐ Standing ☐ Squatting

☐ Lifting / Bending ☐ Light Activity ☐ Kneeling ☐ Reaching

☐ Pushing / Pulling ☐ Other:__________________

What makes it better

☐ Rest ☐ Elevation ☐ Heat ☐ Ice

☐ Medication ☐ Compression ☐ Other:__________________

Do you have any of the following:

☐ Numbness / Tingling / Pins & Needles ☐ Decreased Range of Motion

☐ Cording or Axillary Web Syndrome ☐ Chronic Fatigue

☐ Tightness / Heaviness ☐ Decreased Strength

☐ Loss of Functional Mobility ☐ Swelling / Lymphedema

☐ Family History of Lymphedema / Lipedema ☐ Decreased Strength

☐ Other:__________________

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When was the onset of your swelling? (month, date, year):____________________________________

Where is your swelling located?

- ☐ Right Arm ☐ Left Arm ☐ Both Arms
- ☐ Right Breast ☐ Left Breast ☐ Both Breasts
- ☐ Trunk ☐ Abdomen ☐ Genitals
- ☐ Right Leg ☐ Left Leg ☐ Both Legs
- ☐ Head / Neck ☐ Other

Have you received lymphedema therapy before, check all that apply:

- ☐ No ☐ Yes
- ☐ Manual Lymph Decongestion (MLD) ☐ Compression Bandaging
- ☐ Compression Garments ☐ Exercises
- ☐ Compression Pump ☐ Low Level Light Therapy
- ☐ Manual Therapy (scar or radiated tissue) ☐ Edema Management Education
- ☐ Risk Reduction Education for Lymphedema ☐ Skin Care
- ☐ Nutritional Strategies ☐ Other: _____________________

Do you currently wear compression?

If yes, do you know the style / name of compression? _________________________________

If yes, how often do you wear your compression? _____________________________________

If yes, how old is your compression? ____

Treatment goals:

____

____

I read, acknowledge and signed the:

- ☐ Consent Form ☐ HIPAA Form
- ☐ Financial Form ☐ Medicare Clarification Letter (only if you have medicare)

Please continue to next page if you are an ONCOLOGY Client

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ONCOLOGY

Oncology Diagnosis:____________________________ Date Diagnosed________________________

Recent Surgery (check below) and Date of Surgery: ____________________________________

- ☐ Lumpectomy
- ☐ Mastectomy
- ☐ Partial Mastectomy
- ☐ Reconstruction
- ☐ Reduction and Lift
- ☐ Breast Expanders
- ☐ DIEP Flap / Tram Flap / Lat Flap
- ☐ Ovarian / Oophorectomy
- ☐ Hysterectomy
- ☐ Lung
- ☐ Head / Neck
- ☐ Skin Grafts
- ☐ Vascular Ablation
- ☐ Vein Stent
- ☐ Other: __________________

Please indicate the side of your surgery: ____

Do you have any of the following:

- ☐ Decreased Strength
- ☐ Decreased Range of Motion
- ☐ Chronic Fatigue
- ☐ Cording or Axillary Web Syndrome
- ☐ Brain Fog
- ☐ Loss of Functional Mobility
- ☐ Swelling
- ☐ Numbness / Tingling / Pins & Needles / CIPN
- ☐ Other: ________________________

Any Lymph Node(s) Removed? IF yes, when, how many, and where?

____

Stage and Grade of biopsy? ____

Did you have Chemotherapy? If yes, do you recall the medication name?

____

Did you have Radiation Therapy? If yes, when: ____

Are you on Hormone Therapy? Medication name (if known):__________________________________

Treatment goals:

____

____

I read, acknowledge and signed the:

- ☐ Consent Form
- ☐ HIPAA Form
- ☐ Financial Form
- ☐ Medicare Clarification Letter (only if you have medicare