**HEALTHY LYMPHATICS OF NC, PC**

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 **Healthy Lymphatics-North Wilkesboro office Healthy Lymphatics-Galax VA office**

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**LYMPHEDEMA QUESTIONNAIRE**

**INITIAL INTAKE FORM**

**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **Which extremity has lymphedema or swelling? [ ] Left Arm [ ] Right Arm**

 **(check all that apply) [ ] Other [ ] Left Leg [ ] Right Leg**

1. **How long have you had swelling? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **How long or how fast did the swelling develop? (circle one)**

 **a) Extremely fast (weeks) b) Very fast (months) c) Fast ( up to one year) d) Slow (years)**

1. **Do you ever weep fluid from the swollen limb or body segment? [ ] Yes [ ] No**
2. **Do you have any wounds? [ ] Yes [ ] No**
3. **Have you ever had cellulitis or an infection of the limb, requiring hospitalization?**

 **[ ] Yes [ ] No If yes, how many times? \_\_\_\_\_\_\_ When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **Do you take antibiotics? [ ] Yes [ ] No**
2. **Do you take diuretics or water pills? [ ] Yes [ ] No**
3. **Does anyone in your family have or has had swelling? [ ] Yes [ ] No**
4. **Have you had prior treatment for lymphedema or swelling? (circle all that apply)**

**[ ] Surgery [ ] Antibiotics [ ] Manual Lymph Drainage**

 **[ ] Compression Garment (stocking/sleeve) [ ] Compression Pump**

1. **Have you recently been hospitalized? [ ] Yes [ ] No**

 **If yes, please list reason why.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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1. **What medical/adaptive equipment do you own? (check all that apply)**

**[ ] Walker [ ] Cane [ ] Wheelchair [ ] Lift Chair [ ] Shower Chair [ ] Reacher**

**[ ] Sock-aide [ ] Long-Handled Sponge [ ] Other (please list)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Lymphedema Questionnaire-Initial Intake Form Page 1**

**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **Do you live alone? [ ] Yes [ ] No If No, who do you live with? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
2. **Pain: Do you have any pain? [ ] Yes [ ] No If yes, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

On a scale of 0-10, 0 being no pain and 10 being emergency room pain, how do you rate your pain? (Circle one)

0 1 2 3 4 5 6 7 8 9 10

1. Do you have or have been diagnosed with any of the following? (check all that apply)

[ ] Bronchial Asthma/Recent Attack [ ] Cancer (where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

[ ] COPD [ ] Cardiac Arrhythmia

[ ] CHF [ ] Carotid Sinus Syndrome

[ ] Hypertension (high blood pressure) [ ] MI ( heart attack )

[ ] Diabetes \_\_\_\_\_Insulin-Dependent [ ] Angina

[ ] Allergies ( please list cause of allergic reaction)\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Kidney Problems

[ ] Stroke (which side was affected? [ ] Right [ ] Left [ ] Hemophilia

 [ ] Chronic Venous Insufficiency or Poor Circulation [ ] Stomach Ulcer

 [ ] Diverticulosis/Diverticulitis, Intestinal Disease ( Ileus Stenosis/Hiatal Hernia/GERD)

 [ ] Deep Vein Thrombosis or Blood Clot (how long ago? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 [ ] Paresis/Paralysis [ ] Hyperthyroidism

 [ ] Aortic Aneurysm [ ] Recent Abdominal Surgery

 [ ] Implants \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Are you currently pregnant? \_\_\_\_\_\_\_\_\_

 [ ] Radiation to Abdomen [ ] Abdominal Pain

 [ ] Chron’s Disease [ ] AAA (Present or Repair)

 [ ] Cardiac Edema [ ] Epilepsy

 [ ] Arterial Disease [ ] Gall/Kidney Stones

 [ ] Reflexive Sympathetic Dystrophy (RSD) [ ] Hysterectomy

 [ ] Acute/Present/Current Infections [ ] Recent Pulmonary Edema

 [ ] Active Tuberculosis [ ] Acute Renal Failure

1. What medications are you currently taking? (please be as thorough as possible)

Lymphedema Questionnaire-Initial Intake Form Page 2

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you ever had radiation therapy? [ ] Yes [ ] No When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, what part of the body? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_How many treatments? \_\_\_\_\_\_\_\_\_\_\_\_

1. Have you ever received chemotherapy? [ ] Yes [ ] No When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. What operations have you had, if any? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What physician referred you to our facility? Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. How did you hear about us? (please check as many as needed)

\_\_\_\_\_ Doctor’s office \_\_\_\_\_ Prior Patients \_\_\_\_\_ Physical/Occupational Therapist

\_\_\_\_\_ Radio Announcement \_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Functional Ability: YES NO

ARM(S) SWELLING ONLY

* Can you raise your arm towards ceiling (arm involved?) [ ] [ ]
* Can you touch the top of your head (arm involved?) [ ] [ ]
* Can you touch the back of your neck (arm involved?) [ ] [ ]
* Can you touch behind your waist (arm involved?) [ ] [ ]
* Can you brush/comb your hair (arm involved?) [ ] [ ]
* Can you pick up a penny from a flat surface? (arm involved?) [ ] [ ]
* Can you lace your shoes (arm involved?) [ ] [ ]
* Can you fasten all buttons/zippers/snaps? (arm involved?) [ ] [ ]

 LEG(S) SWELLING ONLY

* Can you drive your car using feet? (leg involved?) [ ] [ ]
* Can you go up/down steps without difficulty? (leg involved?) [ ] [ ]
* Can you sit and stand without difficulty? (leg involved?) [ ] [ ]
* Does the leg or arm involved feel heavy at all times? [ ] [ ]
* Write down 5 activities you cannot do because of the swelling:
1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* How would you rate your quality of life? (Circle one) EXCELLENT VERY GOOD GOOD FAIR POOR
* What is your weight? \_\_\_\_\_\_\_\_\_\_\_\_and height? \_\_\_\_\_\_\_\_\_\_\_\_ BMI? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Do you currently smoke? Yes \_\_\_\_\_\_ No \_\_\_\_\_
* Have you had any of the following therapies this year? ( please circle )

Physical Therapy Occupational Therapy Speech Therapy LYMPHEDEMA

* Have you fallen at all in the past year? Yes \_\_\_\_\_ No \_\_\_\_\_ How many times? \_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lymphedema Questionnaire-Initial Intake Form Page 3

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. If you are treated at this facility, you will then be able to follow a treatment and maintenance program at home. This program may consist of:
2. Elastic sleeve or stocking worn on a daily basis
3. Bandaging of limb overnight if needed
4. Meticulous skin care to avoid infections as prescribed by your therapist
5. Remedial exercises daily to avoid lymph flow

\*\*\*\* The above is necessary to ensure progress for lymphedema treatment and decrease swelling. \*\*\*\*

\*\*\*\*Are you prepared to follow such a program? [ ] Yes [ ] No

 [ ] I would like to discuss this further with my therapist.

Signed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*\*\*PLEASE FEEL FREE TO DISCUSS ANY PROBLEMS, QUESTIONS, CONCERNS

REGARDING YOUR SWELLING WITH THE THERAPIST\*\*\*\*

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