Therapy Intake Form

Name__________________________________________ Date_____________________

Date of birth_____________   Age__________   Occupation__________________________________________

▪ Doctor who referred you for treatment_________________________________________________________

▪ Other physicians or practitioners involved in your care:__________________________________________

<table>
<thead>
<tr>
<th>MEDICAL HISTORY</th>
<th>Y</th>
<th>N</th>
<th>COMMENT</th>
<th>Y</th>
<th>N</th>
<th>COMMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you smoke?</td>
<td></td>
<td></td>
<td>Pregnant</td>
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<tr>
<td>Asthma</td>
<td></td>
<td></td>
<td>High / low blood pressure</td>
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<tr>
<td>Heart disease</td>
<td></td>
<td></td>
<td>Cancer</td>
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<td>Type-</td>
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<tr>
<td>Kidney disease</td>
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<td>Diabetes</td>
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<td>High / low thyroid</td>
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<td>Vascular disease</td>
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<tr>
<td>Frequent headaches</td>
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<td></td>
<td>Epilepsy</td>
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<tr>
<td>Arthritis</td>
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<td></td>
<td>Osteoporosis</td>
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<tr>
<td>Skin problems</td>
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<td></td>
<td>Do you exercise regularly?</td>
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<td></td>
<td>Type-</td>
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<tr>
<td>Poor circulation</td>
<td></td>
<td></td>
<td>Other significant medical history</td>
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<td></td>
<td></td>
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<tr>
<td>Blood clots</td>
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</tbody>
</table>

Family history of swelling:  Y   N

Special Tests (MRI, CT Scan, Bone Scan, X-rays, Nerve Tests, Doppler):
________________________________________________________________________

Other health services you have received/are receiving for this condition (chiropractor, acupuncture, prior physical therapy, other medical treatments etc.):
________________________________________________________________________

▪ Please describe your surgery and dates if applicable:
________________________________________________________________________

• Did you have chemotherapy?  Y   N   If yes what type? ________________________________
• Did you have radiation?  Y   N  If yes, how many treatments? _______________________

• Did you have hormone therapy?  Y   N

• Any problems or complications with surgery, chemo, hormone therapy or radiation? ____________________________________________________________

• Please list all your current prescribed medications, over the counter medications, vitamins, herbs, supplements, and home remedies. Include how much and how often you take the medication:
  __________________________________________________________________________
  __________________________________________________________________________
  __________________________________________________________________________

• Do you take diuretics (water pills)?  Y   N

Please list any allergies:________________________________________________________________________

(If you are experiencing swelling please answer questions #1-7. Otherwise please continue to next page)

1) Where is your swelling? (circle all that apply)
   - Left Arm
   - Left Leg
   - Right Arm
   - Right Leg
   - Left Chest
   - Right Chest
   - Face
   - Genitals

2) When did swelling begin?___________________________________________________

3) Have you had any infections (example: cellulitis)? If so what type?
   __________________________________________________________________________

4) Have you had prior treatment for swelling?  Y   N
   What type of treatment?________________________________________________________________________

5) Was it effective?  Y   N  Did you learn any self-care for swelling?  Y   N

6) Do you have a compression garment?  Y   N  Does it still fit?  Y   N  Does it help?  Y   N

7) What problems does swelling cause you? _________________________________________________

______________________________________________

________________________________________________________________________
Do you currently live in a: ___ house ___ apartment ___ mobile home ___ assisted living

Number of stairs: ___ front ___ back ___ inside                   Ramps:  Y   N

Do you have someone who can help you with your self-care program?____________________

Do you live: ___ alone ___ with family or friends   Who? ______________________________

Please describe any help you receive from friends / family / hired persons / community programs for your daily activities or homemaking: __________________________________________

Please list any equipment in your home to assist you (canes, walkers, wheelchair, tub bench, raised toilet seat, braces, splints, etc.)______________________________________________

Do you drive?  Y   N

Please circle any of the following impairments you have:
  Limited motion  Poor strength  Fatigue  Poor balance
  Incontinence  Difficulty with daily or work activities  Joint Pain
  Feelings of pins and needles: Location __________________________________________

Please rate your fatigue (circle):
  None                            Worst (can’t get out of bed)
                                  0      1      2      3      4      5      6      7      8      9      10

What are your recreational and fitness activities? ___________________________________

What are your goals for therapy? _________________________________________________

Please rate your function (circle):
  Can do nothing                            Can do everything
                                  0      1      2      3      4      5      6      7      8      9      10

Please rate how much this problem is affecting your quality of life (circle):
  None                            Worst
                                  0      1      2      3      4      5      6      7      8      9      10
Pain Assessment:
Do you have pain?  Y  N
If yes, circle the location of your pain on the body chart below.

Please rate the intensity of your pain (circle):

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<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
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</table>

Worst (take me to the hospital)

Patient Signature _______________________________       Date _______

Therapist Signature _______________________________