Therapy Intake Form

Name_____ Date_____

Date of birth_____ Age_____ Occupation_____

▪ Doctor who referred you for treatment_____

▪ Other physicians or practitioners involved in your care:_____

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

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?_____

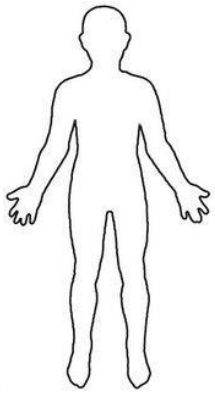
Please rate your function (circle):

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):

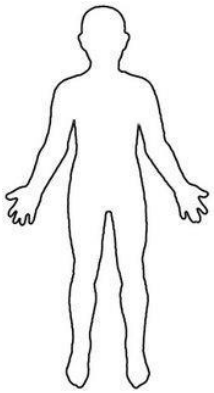
None Worst
0 1 2 3 4 5 6 7 8 9 10

Pain Assessment:
Do you have pain? Y N
If yes, circle the location of your pain on the body chart below.



Right Left

front



Left Right

back

Please rate the intensity of your pain (circle):

None Worst (take me to the hospital)

0 1 2 3 4 5 6 7 8 9 10

Patient Signature _____ Date _____

Therapist Signature _____