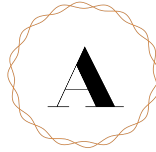

A D V A N C E D
THERAPY SOLUTIONS

120 N Perkins Road Suite F Stillwater, OK 74075❖405.564.2701❖www.ats-stillwater.com

Lymphedema Intake Form

If you are currently receiving **any care services** at home please notify us **prior to completing this form.**

Patient's Name:	SS#:
Address:	Date of Birth:
City, State, Zip:	Home Phone:
Employer:	Work Phone:
E-mail Address:	Cell Phone:

Primary Language:______________________________

Physician:____**Phone:**_____________

Marital Status: (Please circle) ***Single*** ***Married*** ***Divorced*** ***Widowed***

Spouse's Name:	SS#:
Address, if not the same:	Date of Birth:
City, State, Zip:	Home Phone:
Employer:	Work Phone:
E-mail Address:	Cell Phone:

Others living in the home:____

Emergency Contact: ____________________________ **Phone:**_______________________________

- **Relationship to patient:** ____

Insurance:

Primary Insurance	
Insurance Carrier:	Contract/ID Number:
Name on Card:	Group Number:
Date of Birth:	SS# of Primary Insured:

Secondary Insurance	
Insurance Carrier:	Contract/ID Number:
Name on Card:	Group Number:
Date of Birth:	SS# of Primary Insured:

Please check the appropriate box below:
I, the undersigned, ☐certify _☐do NOT certify that I (or my dependent) have insurance coverage with the entity(s) listed above and assign directly to **Advanced Therapy Solutions, LLC** all benefits from the above entity, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize **Advanced Therapy Solutions, LLC** to release all information necessary to secure the payment of benefits.

Reason you have been referred for therapy:
____
____

I**f you have swelling, when did the swelling begin**? ____
Has the swelling changed? _________ If so, when and how? ______________________________

Have you had any of the following occur to the affected area?

Cellulitis / infection ______________ Wounds ____________________________
Drainage / weeping _____________ Major trauma ______________________
Cancer treatment ________________ Deep vein thrombosis ______________

Do you currently have any open wounds? ___________ **Where?** ___________________________
If so, how is the wound being treated? ____
____

What have you tried to improve the swelling?

_____ Elevation _____ Exercise _____ Massage _____ Diuretics
_____ Compression pump _____ Compression garments _____ Compression Wraps

Are there activities that you can not perform, or have become more challenging, since your swelling began / worsened? Please be as specific as possible.

____

____

____

Please circle any physical limitations you are experiencing:

Pain or difficulty using your hands	*Pain or difficulty reaching overhead*
Pain or difficulty bending over	*Difficulty reaching both hands to feet*
Difficulty with self care (bathing, dressing)	*Difficulty with household chores*
Difficulty moving from sitting to standing	*Difficulty walking on level/unlevel surfaces*
Visual Impairment	*Other:*

PAIN ASSESSMENT:
Do you have pain: __________ **If so, where?** ____
____

Intensity: 0 1 2 3 4 5 6 7 8 9 10
<No Pain **Worst Possible Pain>**
Duration of the pain: ____ **Constant** ____ **Intermittent**
Describe the pain: ____
____
What makes the pain worse: ____
What makes the pain better: ____

MEDICAL HISTORY:

	No	**Yes**	**Explain**
Blood Clot			
Cardiac Problems			
Congestive Heart Failure			
Varicose Vein Procedure			
Peripheral Artery Disease			
Diabetes			
Falls			
High Blood Pressure			
Kidney Disease			
Respiratory Problems			
Repeated Infections			
Neurologic Disorder			
Stroke			
Surgeries not related to cancer treatment:			

CANCER TREATMENT:

	Date Began	Date Completed
Chemotherapy:		
Radiation:		
Surgeries:		

MEDICATIONS: Please list or provide a list

_____________________________________ _____________________________________
_____________________________________ _____________________________________
_____________________________________ _____________________________________
_____________________________________ _____________________________________
_____________________________________ _____________________________________
_____________________________________ _____________________________________
_____________________________________ _____________________________________
_____________________________________ _____________________________________

Medication Allergies: ____

Latex Allergy: ____

Tests completed within the past year: (Please circle)

ABI	Echocardiogram	Nerve Conduction Velocity
Angiogram	EEG	Pap Smear
Biopsy of:		
Bone scan	EKG	PET Scan
Bronchoscopy	Lymphscintigraphy	Pulmonary Function Study
CT scan	Mammogram	Stool Tests
Doppler Ultrasound	MRI	Stress Test

GOALS:

What are your goals for treatment? ____
____
____

Is there any other important information that you feel may be helpful to your evaluation or treatment? ____
____
____

Would you like to receive a courtesy reminder for every scheduled appointment? (circle)

Yes *or* ***No***

-If yes, would you like to receive an e-mail or call reminder? ***E-mail*** ***Text*** ***Call***

Please provide the e-mail address or phone number where you would like to receive reminders: ____

Name of person completing this form: ____

Relationship to patient: ___________________________**Phone:** ______________________

Thank you for taking the time to complete this information!

____
Signature of Patient or Responsible Party

____
Relationship to patient

____
Date