



Lymphedema Intake Evaluation

Name: _____

Date: _____

1. How long have you had lymphedema? _____
2. Have you ever had any lymphedema infections? _____
3. Do you ever leak fluid? _____
4. Do you take prophylactics antibiotics? _____
5. Do you take diuretics for lymphedema? _____
6. Do you take benzopyrones for lymphedema? _____
7. Do you take any other drugs for lymphedema? _____
8. Does anyone in your family have lymphedema? _____
9. Which extremity has lymphedema?
 - a. Check all that apply
 - i. Left Arm _____
 - ii. Right Arm _____
 - iii. Left Leg _____
 - iv. Right Leg _____
10. Have you ever had prior treatment for lymphedema? _____
 - a. Check all that apply -
 - i. Surgery _____
 - ii. Compression Garment _____
 - iii. Antibiotics _____
 - iv. Pneumatic pump _____
11. Do you have bronchial asthma? _____
12. Do you have hypertension? _____
13. Do you have diabetes? _____
14. Do you have allergies? _____
15. Do you have any cardiac problems? _____
16. Do you have any kidney problems? _____
17. Do you have any circulatory problems? _____
18. What medication(s) are you currently taking? _____
19. Have you ever had radiation therapy? _____
 - a. If yes, please share more _____

20. Have you ever received chemotherapy? _____
 - a. If yes, please share more _____

21. What operations have you had? _____
 - a. If yes, please share more _____



22. Who referred you to our facility? _____

a. Name: _____

b. Address: _____

c. Phone: (____) _____

23. Can we write to or discuss your lymphedema problem with this physician? YES NO

*If you are treated at this office, you will then be asked to follow a maintenance program at home. This consists of:

a) Elastic sleeves or stocking worn during the day

b) Bandaging of limb overnight

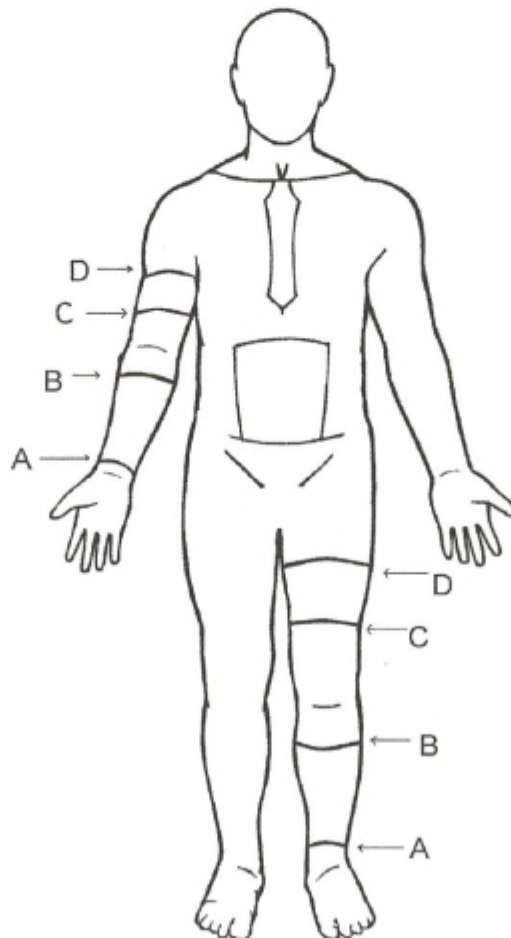
c) Meticulous skin care to avoid infections

d) Remedial exercises to accelerate lymph flow

Lymphedema Measurements

Name: _____

Date: _____





ALT Progress Notes

NAME: _____

DATE: _____

Rate Control: _____

Level Control: _____

Fine Tuner: _____

AXILLARY (Scale of Congestion: 1 is NOT, 3 IS Very)

Left..... 1 2 3
Right 1 2 3

Clavicle 1 2 3

INGUINALS (Scale of Congestion: 1 is NOT, 3 IS Very)

Left 1 2 3
Right 1 2 3

ORGANS (Scale of Congestion: 1 is NOT, 3 IS Very)

Colon 1 2 3
Liver 1 2 3
Spleen 1 2 3
Kidneys 1 2 3

Cisterna Chyli Congested/Clear

Cervicals Congested/Clear

Today the Co-Operator was

Emotional In pain Quiet Talkative Anxious Had new diagnosis data

Overall

Very Sticky Quite Clear Congested initially, but got a lot of movement

Progress Notes: *(Comments about stomach, lungs, glutes, pancreas etc. fit here; as well as how they feel or healing crisis)*

Practitioner's Signature: _____

Practitioner's Signature: _____