Occupational Therapy Lymphedema Intake

Welcome to Occupational Therapy at Rusk County Memorial Hospital. Please fill out this form as thoroughly as possible. Should you have any questions or do not understand a statement please skip it and let your therapist know so that he/she may provide clarification.

Date: __________ Name: ___________________________ Age: _____ Phone: _____________

Who may we call if we cannot reach you: _______________________________ Phone: ____________

Relationship: _____________________________________________________________________

Insurance Information:

Insurance: _________________________________________________________________________

Do you have any of the following: □ Northern Bridges □ Home Health Services □ Medicaid

Briefly describe your symptoms including how and when they began: ________________________________

______________________________________________________________________________

Is there anything that reduces the swelling: ________________________________________________

Is there anything that makes it worse: ____________________________________________________

Do you, or have you recently engaged in or experienced any of the following: (Check all that apply)

☐ Strenuous / Heavy lifting  ☐ Saunas  ☐ Sprain
☐ Gardening  ☐ Knitting  ☐ BP on affect limb
☐ Sun Tanning  ☐ Cracked nail beds  ☐ Travel
☐ Salty foods  ☐ Stress at work / home  ☐ More than normal activity
☐ Hang nails  ☐ Animal bite / Scratch  ☐ Several hours in same position
☐ Injections  ☐ illness  ☐ Steam room
☐ Insect bite / Sting  ☐ Lengthy time on phone  ☐ Sawing
☐ Cut  ☐ Aerobic exercise  ☐ Hot tubs
☐ Surgery  ☐ Weight lifting  ☐ Frequent flying

Complication and / or Additional symptoms:

Have you had infections or skin problems in the swollen area: ☐ Yes  ☐ No

If yes, what and when: _________________________________________________________________

Does swelling occur mainly at night and return to normal in the morning: ☐ Yes  ☐ No

Do you have swelling in your feet and ankles: ☐ Yes  ☐ No  ☐ Sometimes

Types and Dates of Surgeries:
Mastectomy:  
Date: _____  
Type: [ ] Modified  [ ] Partial Lumpectomy  
Which Side: [ ] Right  [ ] Left  [ ] Bilateral

Prostate:  
Date: _____  
Hysterectomy:  
Date: _____

Others with dates: __________________________________________________________________

Surgical Scars: Locations:  
____________________  [ ] Horizontal  [ ] Vertical  
____________________  [ ] Horizontal  [ ] Vertical  
____________________  [ ] Horizontal  [ ] Vertical

Are you in active treatment for cancer:  [ ] Yes  [ ] No

Type: _______________________________  
Stage (If known): _______________________________

Past or Present Treatment:

Chemo-Therapy:  
Started _________  
Finished _________  

Radiation Therapy:  
Started _________  
Finished _________

Areas irradiated:  [ ] Axilla  [ ] Breast  [ ] Other

Hormonal Therapy: _______________________________

Have you experienced any of the following (Please give approximate dates)

- [ ] Congestive heart failure (CHF)
- [ ] Heart Disease
- [ ] Stroke
- [ ] Asthma
- [ ] Varicose Veins
- [ ] Arthritis
- [ ] Salt related swelling
- [ ] Infection in arm
- [ ] Infection in leg
- [ ] Rash, skin disease
- [ ] Kidney Disease
- [ ] Osteoporosis

- [ ] Diabetes  
  * Controlled By: _______________________________

- [ ] Fracture  
  * What Kind: _______________________________

- [ ] Blood Clots  
  * Where: _______________________________

- [ ] Back/Spinal Injury/ Problems  
  * Treated How: _______________________________

- [ ] Infection in Breast
- [ ] Emphysema
- [ ] Urinary tract infection tendency
- [ ] Other: _______________________________

Have you ever been on a drug called COUMADIN?  
[ ] Yes  [ ] No

If yes, for what diagnosis: _______________________________  
How long: _______________________________

Was a filter placed:  [ ] Yes  [ ] No
Daily Living Data

Do you:  □ Live alone  □ With spouse/significant other  □ Family  □ Other: ____________________

Are you a care giver of:

□ Children – How many _____ Ages: ____________________________

□ Adult/s – Type of care: _______________________________________

Physical layout of your home:  □ Ranch  □ Two Story  □ Tri-Level  □ Apt. (Floor)  □ Condo

□ Retirement facility  □ Elevator Available:  □ Yes  □ No

Location of laundry room: ____________________________________________________________

Employment:  □ Full-Time  □ Part-Time  □ Voluntary  □ Retired  □ Homemaker  □ Disabled (cause) ________

Type of Work: _____________________________________________________________________

Activity level:  □ Sedentary  □ Light  □ Moderate  □ Heavy

Functional Abilities

Dominate Hand:  □ Right  □ Left

Rating:  Check each one based on current ability

Grooming

Sponge bathe  □ Unable  □ Need much help  □ Need a little help  □ Independent
Brush teeth  □ Unable  □ Need much help  □ Need a little help  □ Independent
Bruch/Comb hair  □ Unable  □ Need much help  □ Need a little help  □ Independent
Shave  □ Unable  □ Need much help  □ Need a little help  □ Independent

Bathing

In/Out of tub  □ Unable  □ Need much help  □ Need a little help  □ Independent
Shampoo hair  □ Unable  □ Need much help  □ Need a little help  □ Independent
Wash/Dry back  □ Unable  □ Need much help  □ Need a little help  □ Independent
Wash/Dry feet  □ Unable  □ Need much help  □ Need a little help  □ Independent
Toileting  □ Unable  □ Need much help  □ Need a little help  □ Independent

Dressing

Upper body  □ Unable  □ Need much help  □ Need a little help  □ Independent
Fasteners  □ Unable  □ Need much help  □ Need a little help  □ Independent
Buttons  □ Unable  □ Need much help  □ Need a little help  □ Independent
Snaps  □ Unable  □ Need much help  □ Need a little help  □ Independent
Hooks  □ Unable  □ Need much help  □ Need a little help  □ Independent
Zippers  □ Unable  □ Need much help  □ Need a little help  □ Independent

Activity

Lower body  □ Unable  □ Need much help  □ Need a little help  □ Independent
Socks  □ Unable  □ Need much help  □ Need a little help  □ Independent
Shoes  □ Unable  □ Need much help  □ Need a little help  □ Independent

Mobility

Walking  □ Unable  □ Need much help  □ Need a little help  □ Independent
Stairs  □ Unable  □ Need much help  □ Need a little help  □ Independent
Sit to stand  □ Unable  □ Need much help  □ Need a little help  □ Independent
Homemaking

Laundry (lifting)  □ Unable □ Need much help □ Need a little help □ Independent
Ironing  □ Unable □ Need much help □ Need a little help □ Independent
Cleaning (dusting)  □ Unable □ Need much help □ Need a little help □ Independent
Scouring sink/tub  □ Unable □ Need much help □ Need a little help □ Independent
Vacuuming  □ Unable □ Need much help □ Need a little help □ Independent
Cooking  □ Unable □ Need much help □ Need a little help □ Independent
Grocery shopping  □ Unable □ Need much help □ Need a little help □ Independent
Other errands  □ Unable □ Need much help □ Need a little help □ Independent

Home maintenance

Driving  □ Unable □ Need much help □ Need a little help □ Independent
Yard care  □ Unable □ Need much help □ Need a little help □ Independent
Car care  □ Unable □ Need much help □ Need a little help □ Independent
Home repairs  □ Unable □ Need much help □ Need a little help □ Independent

LEISURE: List leisure activities you currently engage in and those you can no longer participate in because of the edema / lymphedema.

Able to do: ____________________________________________
____________________________________________________________________
____________________________________________________________________
Unable to do: ____________________________________________
____________________________________________________________________
____________________________________________________________________

Have you tried any of the following treatments:

□ Pump (type) ____________________________  □ Compression garments
□ Lympho Press  □ Massage therapy
□ Jobst  □ Reid Sleeve
□ Physical Therapy  □ Occupational Therapy
□ Other: ____________________________  □ Medication _______________________

List Medications that you are taking including over–the-counter, home remedies, & any vitamins

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<tr>
<th>Medication</th>
<th>Dose &amp; Frequency</th>
<th>Reason</th>
<th>Physician</th>
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ALLERGIES OR ADVERSE REACATION you may have to medications or materials. Example: plastics, tape, sprays, cleaners, fabrics, Etc.

Name of Allergy: ____________________________________________
____________________________________________________________________
____________________________________________________________________
What Happens: ____________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
Lymphedema Symptom Assessment

On a Scale of 0 – 10

Do you experience tension of the swollen arm or leg or chest? __________
(0= No Tension) (10= Tension as bad as it could be)

Do you experience heaviness? __________
(0= No Heaviness) (10= Heaviness as bad as it could be)

Do you experience pain? __________
(0= No Pain) (10= pain as bad as it could possibly be)

Do you experience abnormal sensations of the swollen arm or leg? __________
(0= No Abnormal Sensation) (10= Abnormal as bad as it could possibly be)

Do you experience hardness of the skin in the arm, leg, or chest? __________
(0= No Hardness) (10= Hard as it could possibly be)

If we treat you here in our office you will be asked to follow a maintenance program at home. This may consist of:

- Elastic sleeve or stocking worn during the day
- Bandaging of the limb overnight
- Meticulous skin care to avoid infection
- Remedial exercises to accelerate lymph flow

ARE YOU PREPARED TO FOLLOW SUCH A PROGRAM: ☐ Yes ☐ No

Signature: _____________________________
Photography Release Form

I ____________________ hereby give Rusk County Memorial Hospital the absolute and irrevocable right to take and permission to use photographs of me, or in which I may be included with others. Photographs are used to display baseline and summary information necessary to determine progress.

A) To copyright the same in said organization’s own name or any name that they may choose, and/or
B) To use re-use, publish and republish the same in whole or in parts, individually or in conjunction with other photographs, in any medium and for the purpose of medical information of the public, medical staff of clinic employees, including (but not by the way of limitation) illustration, promotion, and advertising and trade, and/or
C) To use my name in connection therewith if they so choose □ Yes □ No
D) Restriction: _____________________ No facial photographs __________ Other: ________
____________________________________________________________________________

I hereby release Rusk County Memorial Hospital from any and all claims and demands arising out of or in conjunction with the use of photographs, including but not limited to any and all claims of libel, invasion, of privacy etc.

This authorization and release shall also ensure to the benefit of the legal representatives, licensees and assigns of Rusk County Memorial Hospital

I am over the age of eighteen (18), have read the foregoing and fully understand the contents thereof.

ADULT RELEASE

______________________________    ______________________________
Subjects Name       Minors Name

______________________________
Signature        Signature-Parent, Guardian

______________________________
Witness Signature       Date

MINOR RELEASE

______________________________    ______________________________
Subjects Name       Minors Name

______________________________
Signature        Signature-Parent, Guardian

______________________________
Relationship to Subject

______________________________
Witness Signature       Date
To Our Clients:

The Rehab Department at Rusk County Memorial Hospital has the following policy in place:

- It is your responsibility to check with your insurance company regarding therapy related coverage. Therapy not covered by your insurance company is your responsibility.

- You must notify the therapist/receptionist of any changes in your insurance while receiving therapy services.
  - Some insurance companies require prior authorization before treatment

- Three appointments of no-show’s or cancellation received less than 24 hours in advance will result in your discharge from therapy

☐ I have read and understand the rehab policy.

____________________________  ____/____/_____
Client Signature     Date

____________________________  ____/____/_____
Therapist Signature     Date