



12006 W. 87th St. Pkwy
Lenexa, Kansas 66215

913.601.8151 | PWRPHYSIO.COM

LYMPHEDEMA THERAPY PATIENT INTAKE FORM

Patient name: _____

DOB: _____

Referring MD: _____

Phone: _____

Specialist MD: _____

Phone: _____

SWELLING HISTORY body part: _____

I am currently experiencing:

Swelling	Rash	Shortness of breath	Pain
Weakness	Impaired motion	Numbness/tingling	Open
wounds			
Heaviness/tightness/fullness		Skin changes: dry/discolored/weeping/ hardness	

When did these issues begin? _____

Family history of same issues? YES/NO

THERAPY HISTORY body part: _____

When _____ Where _____

Are you currently seeing OT or PT for any concerns?

Are you currently receiving hospice or HOME HEALTH services that include nursing, PT, OT or ST?

YES / NO agency name and phone: _____



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Have you had lymphedema or lipedema therapy before? YES / NO

What treatments did you receive?:

Manual Lymph Drainage

Compression garments

Compression bandage
wrapping

Diuretics/water pill

Kinesio taping

Self manual lymph drainage

Antibiotics

Pneumatic compression

pump_____

Other:_____

Do you have any allergies to tape, latex or topical skin products? YES / NO

If you have pain, please rate on scale of 0 (no pain) to 10 (worst imaginable)

Current:_____ Worst:_____ Best:_____

Pain is

located:_____

Pain is: Sharp Dull Ache Heaviness Burning Constant

Other:_____