Client History

DEMOGRAPHICS

Name: ________________________________ Date of Birth: ______________________ Age: ________

Home Phone: ________________ Cell Phone: ________________ Email: _______________________

Best way to contact: □ Home □ Cell □ Email

Current Weight: _______________ Height: ________________ Hand Preference: □ Right □ Left

To be completed by lymphedema staff:

Blood Pressure:	Heart Rate:	Respiratory Rate:	Pulse Oximetry:

PHYSICIAN INFORMATION

Referring Physician: __________________________ Physician's Specialty: ______________________

Referring Physician Phone #: _________________ Referring Physician Fax #: _________________

Please list all medical providers involved in your health care:

Name of Medical Provider	Specialty	Phone Number

SWELLING HISTORY Currently I am experiencing (please circle)

Swelling Weakness Open sores that will not heal Pain Heaviness/Tightness/Fullness Skin Changes: dry, discolored, weeping, hard	Rash Shortness of breath Impaired motion Numbness/Tingling Other:	Which body part is affected? ____________ Date of initial onset of symptoms: ________ Does anyone in your immediate family have a history of swelling? ____________________________

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MEDICAL HISTORY *IN AREAS WITH A *, PLEASE EXPLAIN AND LIST DATES*

- ❑ High Blood Pressure
- ❑ Asthma
- ❑ Congestive Heart Failure
- ❑ Paralysis
- ❑ Diabetes
- ❑ Arrhythmia
- ❑ Arterial Disease
- ❑ GERD (reflux)
- ❑ Renal (Kidney Disease)
- ❑ Neuropathy
- ❑ Thyroid Problems
- ❑ Crohn's Disease
- ❑ Fractures
- ❑ Scoliosis
- ❑ Vertigo
- ❑ Cancer
- ❑ Breathing Problems
- ❑ Heart Problems
- ❑ Circulation Problems
- ❑ Heart Problems
- ❑ Deep Vein Thrombosis (Blood Clot)
- ❑ Other:

❑ **Latex Allergy ***

Medications: (name, dose, frequency) (include herbal supplements, vitamins, over-the-counter-medication)

Medication allergies:

Surgical History:

Breast surgery
❑ *N/A*

❑ Left ❑ Both
❑ Right ❑ Reconstruction
Reconstruction: (date/type)

❑ Lumpectomy
❑ Axillary node dissection
❑ Modified/radical mastectomy
❑ Simple/total mastectomy

Abdominal surgery (Please list dates)
❑ N/A

❑ Gall bladder
❑ Hysterectomy
❑ Hernia Repair
❑ Plastic Surgery
❑ Other:

Prostate surgery ❑ *N/A* ❑ Date:

Cancer Treatments:

Have you had or are currently undergoing any of the following?:

❑ **Chemotherapy:** # of tx: ___________
Year: _________

Response/Complications of tx:

❑ **Radiation:** # of tx: ___________
Year: _________

Response/Complications of tx:

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Therapy History

Have you received ANY outpatient Physical, Speech or occupational Therapy Services this year? Yes ☐ No ☐

Are you ***currently*** being seen for outpatient Physical, Speech or Occupational Therapy Services? Yes ☐ No ☐

Are you ***currently*** receiving home health services including nursing, Physical, Speech, Occupational Therapy Services or home health aide?

Have you had lymphedema therapy before? Yes ☐ No ☐ If yes, where and when?

What treatments have you received?

- ☐ Manual Lymphatic Drainage
- ☐ Diuretics
- ☐ Kinesio Taping
- ☐ Other:
- ☐ Compression Bandaging
- ☐ Antibiotics
- ☐ Self Drainage
- ☐ Pneumatic Compression Pump
- ☐ Diuretics
- ☐ Compression Garments

Social History

Do you live in a: ☐ House ☐ Apartment/Condo ☐ One Level ☐ Two Level

Do you live alone? Yes ☐ No ☐ Do you sleep in a ☐ Bed ☐ Chair ☐ Other: ____________________

Do you have help to participate in lymphedema therapy? ☐ Yes ☐ No

Do you require assistance for walking or getting in/out of bed or chair? ☐ Yes ☐ No

Do you require assistance for bathing/dressing/home management tasks? ☐ Yes ☐ No

Are you currently working? ☐ Yes ☐ No ☐ Retired

Occupation: ____

What recreational activities do you do on a regular basis (ie, walking, swimming, weightlifting, hiking, crafts)?

How many days a week are you physically active? ☐ 0 ☐ 1-2 ☐ 3-5 ☐ 6-7

Please list 3 **important activities** that you are unable to do or that you are having difficulty doing as a result of your swelling?

1. ____

2. ____

3. ____

Please list 2 **important goals** that you would like The Lymph Clinic help you achieve?

1. ____

2. ____

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PAIN SCALE

On a scale from 0 (no pain) to 10 (the works pain you could imagine), what is your pain:
NOW: 0 1 2 3 4 5 6 7 8 9 10
WORST: 0 1 2 3 4 5 6 7 8 9 10
BEST: 0 1 2 3 4 5 6 7 8 9 10
Where is your pain centered? ____
Please describe your pain :____
What increases your pain :____
What decreases your pain :____
Is there anything else you would like us to know regarding your pain:

GOALS
Please list your goals for evaluation and/or treatment for lymphedema therapy:
1. ____
2. ____
3. ____

LEARNING

How do you best learn? ☐ Visual ☐ Auditory ☐ Demonstration ☐ Video

I have filled out this form to the best of my knowledge and understand that it is important to relay any health related changes to my therapist at my next visit. Even little changes such as prescription doses or new medications can have an impact on my body's response to therapy.

Client signature: ____ Date: __________________________

Therapist signature: _______________________________________ Date: __________________________

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Body of Health
Home of The Lymph Clinic

HEALTH TEAM AGREEMENT

2321 HENRY CLOWER BLVD, STE A
SNELLVILLE, GA 30078
678-344-0050

Lymphedema is a chronic condition that occurs when the lymphatic system has been damaged or impaired. In order to treat this condition, and reduce swelling, there must be a team approach. Body of Health is a part of your health team to help you achieve a better quality of life through lymphatic therapies.

We have set up a program that works. Our lead therapist has combined many years of experience in this field to come up with a program that effectively reduces swelling and improves function.

This program consists of:

1. Daily/weekly visits for evaluation, treatment, and measurements by the therapist.
2. Meticulous skin care routine.
3. Massage/manual lymph drainage, which may include the chest and groin.
4. Bandaging of the limb 20-23 hours a day.
5. Self-bandaging on weekends. (You and your caregiver will be instructed in self-massage and self –bandaging.)
6. Therapeutic exercises to accelerate lymph flow.
7. Instruction in a home maintenance program.

While this routine seems demanding, it is not forever. Once the limb or area is under control, you can move to compression garments and a maintenance routine. Body of Health is a comprehensive Lymphedema facility. We offer garments as well as helpful hints to make home care simple and doable.

Your commitment to the treatment program will lead to quicker recovery and better quality of life. Please note that if you choose not to fully participate in the above outlined program this may lead to poor results.

Are you prepared to follow this program? ___ Yes ___ No

This agreement form has been explained to me and I certify that I fully understand its contents.

______________________________ ____________
Client Signature Date

______________________________ ____________
Witness Date

FOR CLINIC USE ONLY

Attendance Record		
Date:	Comments:	Initials

Financial Policy

PLEASE READ THIS VERY CAREFULLY

1. Your insurance plan is an agreement between you, your employer (if applicable) and your insurance carrier. The Lymph Clinic LLC is not a partner in this arrangement. Therefore, any CO-PAYMENTS, CO-INSURANCE and DEDUCTIBLES are due before the insurance claim will be filed.
2. It is your responsibility to determine if The Lymph Clinic LLC or any other providers to which you may be referred are in your network for Preferred Provider. If your insurance denies payment for treatment because you did not notify our staff of a Preferred Provider, that will be between you and your insurance company.
3. As of January 1st 2017, statements will be sent to you monthly from this office. Payment for a balance is expected in full. If payment in full is not received by the THIRD statement, you may be dismissed as a client from this practice. Balances not paid within 90 days are subject to client dismissal and/or submission to our Collection agency.
4. If you receive a statement and find you cannot pay the balance in full, please contact our office to make payment arrangements.
5. It is your responsibility to provide our office with your correct contact information (name, address & phone number) for which to send statements or call you if necessary.
6. Please be advised that should this account be referred to a collections agency or attorney for the purposes of collecting outstanding balances you will be responsible for covering the costs.
7. Please be advised that if you do not come to a scheduled appointment you will be charged a $50.00 “No Show” fee. A same day cancellation will also result in a $50 cancellation fee unless you have a doctor’s excuse.
8. Please be advised that you will be billed and are expected to pay all outstanding balances as determined by the insurance company. Should you believe you are not responsible for the balance, you will need to provided out office with documentation or you will need to file an appeal with your insurance company.
9. Photocopies of all Business Office forms that I sign are also considered as valid as the original.

*******I have read and understand all of the above and have agreed to these statements.**

Client Signature: ____

If the patient is under the age of 18, parent or guardian signature:

____ Date: ______________________