PATIENT'S NAME: _____

Do you have any pain? ☐ Yes ☐ No

If yes, please rate your pain using the following scale

Pain — Moderate Pain — Severe Pain

1 2 3 4 5 6 7 8 9 10

Please describe the pain. (Circle all that apply)

Dull / Aching / Throbbing / Excruciating / Pulling / Constant / Intermittent

Where is the pain located? _____

What aggravates the pain? _____

What relieves the pain? _____

LYMPHEDEMA HISTORY

How long have you had swelling? _____ Date first noticed: _____

Do you know what caused it? ☐ Yes ☐ No If yes, please explain: _____

What previous treatment(s) have you had? ☐ None ☐ Elevation ☐ Compression Bandaging

Pump: What kind? _____ What pressure? _____ Number of doses: _____

Garment/sleeve: What kind? _____ What pressure? _____ Using now? ☐ Yes ☐ No

Manual lymph therapy: Where/when? _____ Number of treatments: ____

Diuretics: Which drug(s)? _____

Have you ever had cellulites (infection) in the affected limb? ☐ Yes ☐ No If yes, when? _____

Did you take antibiotics? ☐ Yes ☐ No If yes, which drug(s)? _____

☐ Intravenous ☐ Oral

Dates of hospitalization, if applicable: _____

Please rate how your Lymphedema has affected your life.

Note at All — Moderately — Severely

1 2 3 4 5 6 7 8 9 10

What daily activities have been affected by swelling or pain? _____

_____

What are your goals and expectations from physical therapy treatment? _____

_____

Other conditions, questions and/or comments you have: _____

_____

Therapist Signature/License Number: _____ Date: _____