Angie Armstrong-Dupre, RMT
Registered Massage Therapist, Certified MLD/Lymphedema Therapist
ADP Authorizer for Lymphedema compression garments
Lifetime Wellness Center,401-3090 Dougall Ave. Windsor, ON, N9E 1S4
e-mail:**aarmstrongmassage@gmail.com**
office519-250-6288 fax 519-250-6299

LYMPHEDEMA INTAKE FORMS

PERSONAL INFORMATION

Name: _____ Date of Birth: _____ Age: ____

Address: _____ Postal Code: _____

Phone (day): _____ (evening): _____ (other): _____

Email Address: (Please print) _____

I give expressed consent to receive emails for appointment updates, informational newsletter and other updates.

Signature: _____

Emergency Contact: _____Relationship:_____ Phone:_____

Occupation: _____ Hours worked per week: _____

Recreational Activities: _____ Frequency: _____

How did you hear about me? _____

Medical Doctor: _____ Address: _____ Phone:_____

HEALTH HISTORY (✓Please indicate the conditions that apply)

- ☐ AIDS/HIV
- ☐ Allergies
- ☐ Sinus infections (frequent)
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Shortness of breath
- ☐ Chronic chest congestion
- ☐ Chronic cough
- ☐ Broken Bones
- ☐ Cancer
- ☐ Chest pain
- ☐ Diagnosed Heart Disease
- ☐ Circulation Problems
- ☐ Stroke
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Dizziness or blackouts
- ☐ Depression/Anxiety
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ Head injury
- ☐ Headaches (migraine)
- ☐ Headaches (sinus)
- ☐ Headaches (tension)
- ☐ Hearing loss
- ☐ Vision loss
- ☐ Multiple Sclerosis
- ☐ Night pain
- ☐ Night sweats
- ☐ Sleep disturbed by pain
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's disease
- ☐ Varicose veins
- ☐ Poor circulation
- ☐ Phlebitis
- ☐ Sensitive skin
- ☐ Rashes (frequent)
- ☐ Skin eruptions (frequent)
- ☐ Bruise easily
- ☐ Back pain
- ☐ Neck pain
- ☐ Shoulder pain
- ☐ Thyroid problems
- ☐ Chronic constipation

- ☐ Difficult digestion
- ☐ Frequent urination
- ☐ Pregnant currently

Other:_____ _____

Angie Armstrong-Dupre, RMT
Registered Massage Therapist, Certified MLD/Lymphedema Therapist
ADP Authorizer for Lymphedema compression garments
Lifetime Wellness Center, 401-3090 Dougall Ave. Windsor, ON, N9E 1S4
e-mail:**aarmstrongmassage@gmail.com**
office 519-250-6288 fax 519-250-6299

LYMPHEDEMA DIAGNOSE

Have you been diagnosed by a Physician with:

(Lymphedema _____ if so: Primary _____ Secondary_____**)Lipedema** ____ **Chronic Venous Insufficiency** _____

If yes, by whom: _____

If not, explain why you think you have Lymphedema: _____

How long have you had the diagnose? _____ When did lymphedema start? _____

Do you currently experience swelling? (Please circle all that apply)

rightarm / left arm /both arms / breast / right leg / left leg / head / neck / genital /

Other, please explain: _____

MALIGNANT HISTORY (If no history of cancer please go to Lymphedema History)

Have you been treated for cancer or malignant disease? (Please circle) **No** **Yes** Type: _____

Have you had any surgery (indicate dates and type)?
_____

Did you have any lymph nodes removed? (Please circle) **No** **Yes** Where: _____

How many: _____ How many malignant: _____

Have you had Chemotherapy?(Please circle) **No** **Yes**Location/type/duration: _____

_____

Did you receive radiation therapy for cancer?(Please circle) **No** **Yes**Location/duration: _____

_____

Present status of cancer: _____ ongoing treatments/frequency: _____

Oncologist's name: _____ Date last visit: _____

Other related information: _____

Angie Armstrong-Dupre, RMT
Registered Massage Therapist, Certified MLD/Lymphedema Therapist
ADP Authorizer for Lymphedema compression garments
Lifetime Wellness Center, 401-3090 Dougall Ave. Windsor, ON, N9E 1S4
e-mail:**aarmstrongmassage@gmail.com**
office 519-250-6288 fax 519-250-6299

LYMPHEDEMA HISTORY

Have you had any infections (Cellulitis)?(Please circle) **No** **Yes** If yes, where and how long ago? _____

Was it treated with antibiotics? (Please circle) **No** **Yes**What type of antibiotics? _____

At home, do you have someone to help you with day-to-day functions?(Please circle) **No** **YesWho**: _____

Are you allergic to :(Please circle)**Latex** **Surgical Tape** **Foam Products** Other: _____

LYPHEDEMA TREATMENT

For treatment of Lymphedema you will be asked to follow a maintenance program at home. This consists of:
a. Bandaging (Intensive Phase) Elastic sleeve or stocking worn during the day (Maintenance Phase).
b. Bandaging (Intensive Phase) Night time garment if indicated (Maintenance Phase).
c. Meticulous skin care to avoid infections.
d. Remedial exercises to accelerate lymph flow.
e. Self-management education

Are you prepared to make a commitment to the treatment program explained to you by the Therapist? (Please circle)**Yes** **No** Comments: _____

SENSITIVE AREA CONSENT

If you have arm lymphedema, the therapist will need to work on the **chest/breast area** in order to provide effective care. Do you consent to the treatment of your chest/breast area?

Please CIRCLE and Signature Yes _____ No _____

If you have leg lymphedema, the therapist will need to work on **the upper inside/medial thigh and buttock area** in order to provide effective care. Do you consent to the treatment of these areas?

I have read this Intake Form and answered all the questions, I give consent to the therapist.

Signed: _____ Date: _____

The therapist may contact my medical doctor/oncologist and I hereby give permission to do so.

_____ Date: _____

Please CIRCLE and SignatureYes _____No _____