THRIVE TOGETHER
HEALING ARTS

thrivetogetherseattle.com

Jennifer Keller
Massage License
MA61050095
NPI 1730705708

206-343-9653
jennifer@thrivetogetherseattle.com

3250 Airport Way S
Suite 743
Seattle, WA 98134

Name: _____

DOB: _____

Completed by: ☐ Client (listed above) ☐ Other: _____

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

☐ right arm ☐ left arm ☐ both arms ☐ breast ☐ right leg ☐ left leg

☐ both legs ☐ genital ☐ head & neck

Other, please explain:

_____

Have you been diagnosed with lymphedema? ☐ Yes ☐ No
If yes, by whom:

_____

How long have you had swelling/lymphedema?

_____

Was there a triggering event which caused the swelling/lymphedema?

_____

Please describe briefly how and why your swelling/lymphedema developed:

_____

_____

Have you had any surgery? ☐ Yes ☐ No
If yes, list surgeries and dates:

_____

_____

_____

Have you had any lymph nodes removed? ☐ Yes ☐ No
If yes, how many:

_____

Have you ever received radiation therapy for cancer? ☐ Yes ☐ No
If yes, list area of radiation and dates here:

_____

_____

_____

Have you had chemotherapy? ☐ Yes ☐ No
If yes, how long ago?

_____

Have you had any infections (cellulitis)? ☐ Yes ☐ No
If yes, how long ago was the last one?

_____

Is there a family history of lymphedema? ☐ Yes ☐ No
If yes, please explain:

_____

Do you have pain? ☐ Yes ☐ No
If yes, please explain:

_____

_____

Do you have any loss of function or mobility? ☐ Yes ☐ No
If yes, please explain:

_____

_____

Do you have difficulties with any of the following?

☐ Walking ☐ Reaching feet and toes ☐ Preparing meals

☐ Dressing ☐ Bathing/showering ☐ Other

If other, please explain:

_____

_____

What is your current living situation?

☐ Private home/apartment (alone) ☐ Nursing home ☐ Hospice

☐ Home with spouse or companion ☐ Assisted living ☐ Other

If other, please explain:

_____

Do you currently suffer from (or have you had) any of the following:

☐ Asthma
☐ Bronchitis
☐ Difficulties breathing
☐ Irregular heart beat
☐ Heart edema
☐ Hypertension
☐ Hyperthyroidism
☐ Kidney failure
☐ Diabetes
☐ Infections (cellulitis)
☐ Sleep apnea
☐ Crohn's Disease
☐ Diverticulitis
☐ Recent abdominal surgery
☐ Unexplained pain
☐ Deep venous thrombosis (blood clot)
☐ Latex allergy
☐ Malignancy(cancer)

Do you have any other medical problems not listed above? ☐ Yes ☐ No

If yes, please explain:

_____

Are you allergic to: ☐ Latex ☐ Surgical Tape ☐ Foam Products ☐ Other
If other, please explain:

_____

Are you taking any medication? ☐ Yes ☐ No
If yes, list medications and amounts here:

_____

_____

At the time you are completing this, are you pregnant or is there a chance you could be pregnant? ☐ Yes ☐ No

PREVIOUS TREATMENTS
Have you had previous treatment for swelling/lymphedema? ☐ Yes ☐ No
If yes, circle ALL that apply:

☐ Compression garments ☐ Manual Lymph Drainage (MLD)

☐ Compression pump ☐ Compression bandaging ☐ Flexitouch

☐ Low level laser ☐ Lymphedema Exercise

If yes, please explain your experience, success, or lack of success:

_____

_____

_____

_____

Do you currently wear a compression sleeve or stocking? ☐ Yes ☐ No
If yes, how often do you wear it and how old is it?:

_____

Do you currently use compression at night? ☐ Yes ☐ No
If yes, please explain:

_____

Do you exercise regularly? ☐ Yes ☐ No
If yes, please describe:

_____

Are you familiar with the National Lymphedema Network? ☐ Yes ☐ No

Are you familiar with the precautions (risk-reduction practices) for Lymphedema?

☐ Yes ☐ No

Are you a member of a breast cancer or lymphedema support group?

☐ Yes ☐ No

If yes, please describe:

_____

What is the reason that you are seeking help?

_____

_____

What are your treatment goals?

_____

_____

_____

Is there anything else you would like to tell us at this time?

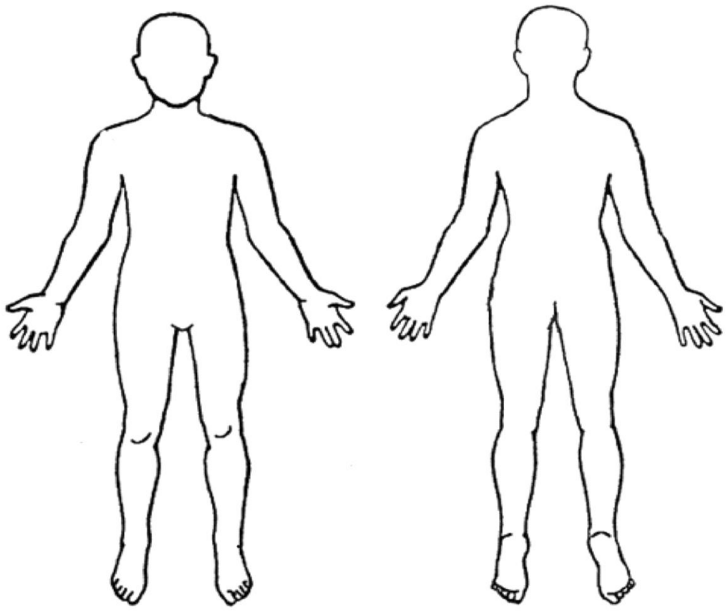
_____

_____

_____

This page of the questionnaire to be completed by your therapist

KEY
Lymphedema: ///
Scar(s):
Node removal: ♦
Radiation field: □
Radiation fibrosis: # #
Pain/Sensory deficits: ✶



Therapist Notes: