TheBodyWorks! LLC

Lymphedema Intake 10/2020

First Name:_____ Last Name:_____

Your Health

1. Have you been under Physician care within the last year? If so, why? ☐ Yes ☐ No

_____

2. Have you been referred by a Physician to us? If so, why? ☐ Yes ☐ No

_____

3. Physician Name and Contact Info: _____

4. List all medications that you take regularly: _____

_____

Please check YES or NO. Please explain any Yes answers!

Y_____N_____Allergies: _____

Y_____N_____Asthma: _____

Y_____N_____Bronchitis: _____

Y_____N_____Cancer: _____

Y_____N_____Cardiac Edema: _____

Y_____N_____Congestive Heart Failure: _____

Y_____N_____Deep Vein Thrombosis: _____

Y_____N_____Infection: _____

Y_____N_____Carotid Sinus Syndrome: _____

Y_____N_____Cardiac Arrhythmia: _____

Y_____N_____Stroke: _____

Y_____N_____Abdominal Surgery: _____

Y_____N_____Aortic Aneurysm: _____

Y_____N_____Crohn's Disease, Colitis: _____

Y_____N_____Abdominal Surgery: _____

Y_____N_____Diverticulitis: _____

Y_____N_____Abdominal Surgery: _____

Y_____N_____Unexplained Belly Pain: _____

Client Signature:_____ Date:_____