Coulee Therapeutic Massage LLC

Heather Odenbach BS, LMT, CMLD

Date:_____

Name:_____ **DOB**: _____

Address:_____

Phone:_____ **Email:**_____

Emergency Contact:_____

Person responsible for payment:_____

Occupation:_____ **Were you referred by anyone?**_____

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

right arm left arm both arms breast right leg left leg both legs 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 a 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

Is 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 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 □ Malignancy (cancer) □	□ Crohn's Disease □ Diverticulitis □ Recent abdominal surgery □ Unexplained pain □ Deep venous thrombosis (blood clot) □ Latex allergy □

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

If yes, please explain: _____

_____

Do you have any allergies? □ Yes □ No

If yes, please explain: _____

_____

Are you taking any medication? □ Yes □ No

If yes, list medications and amounts here: _____

_____

At the time you are completing this, ar 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, check ALL that apply:

□ Manual Lymph Drainage (MLD) □ Compression bandaging □ Lymphedema exercise	□ Compression pump □ Flexitouch □ Low level laser	□ Compression garments □ □

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: _____

_____

What are your treatment goals? _____

_____

_____

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

_____

_____