

Patient History Form—Lymphedema

Name: _____ Today's Date: ____/____/____

Home Address: _____ Date of Birth: ____/____/____

City, State, Zip Code: _____ Spouse/Partner: _____

Phone (Home): _____ (Work): _____ (Mobile): _____

Email Address: _____ Referring Physician: _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Medical History: Please mark all conditions that apply

- | | |
|---|--|
| <input type="checkbox"/> Diabetes (type 1 (Insulin Dependent) or 2 (Non Insulin)) | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Infectious diseases (incl. HIV/AIDS) |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Trauma | <input type="checkbox"/> Lung |
| <input type="checkbox"/> Vascular Problems | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Metal implants | <input type="checkbox"/> Other medical conditions (not listed) |

Explain Any areas Noted or Marked Above: _____

Current Medications (Name Dose & Frequency): _____

Medication Allergies: _____

Over the counter supplements: _____

Lymphedema of:

- | | | |
|---------------------------------------|-----------------------------------|------------------------------------|
| <input type="checkbox"/> Right Arm | <input type="checkbox"/> Left Arm | <input type="checkbox"/> Head/Neck |
| <input type="checkbox"/> Right Leg | <input type="checkbox"/> Left Leg | <input type="checkbox"/> Genital |
| <input type="checkbox"/> Other: _____ | | |

Breast surgery:

- | | | |
|---|--|--|
| <input type="checkbox"/> Right Side (year _____) | <input type="checkbox"/> Left Side (year _____) | <input type="checkbox"/> Both (year _____) |
| <input type="checkbox"/> Lumpectomy | <input type="checkbox"/> Simple/Total Mastectomy | <input type="checkbox"/> Modified/Radical |
| <input type="checkbox"/> Axillary node dissection | <input type="checkbox"/> Sentinel Node biopsy | |

Abdominal surgery:

- | |
|--|
| <input type="checkbox"/> Pelvic resection (date _____) |
| <input type="checkbox"/> Hysterectomy (date _____) |
| <input type="checkbox"/> Other abdominal surgeries (please list) _____ |

Prostate surgery (date: _____)
 Head & Neck (year: _____) Radiation? _____

Other Surgeries, please list (incl. year) _____

Have you had:

Chemotherapy # of treatments: _____ Year: _____
 Radiation # of treatments: _____ Year: _____
 Infection(s) Antibiotics: _____ Hospitalized: _____

Do you know how your Lymphedema developed? If so, describe how and why: _____

How long have you had Lymphedema? _____

Have you had previous intervention for your Lymphedema? Yes | No

Do you have any pain associated with your Lymphedema? Yes | No

Do you wear a compression sleeve/garment at present? Yes | No

Have you ever leaked lymph fluid? Yes | No

Have you ever had open sores on your affected limb? Yes | No

What tests/studies have you done for your Lymphedema? _____

Have you traveled outside of the United States? Yes | No

Do you exercise regularly? Yes | No

Do you smoke or drink? Yes | No

What is your daily lifting activity? Light | Moderate | Heavy

What can't you do because of your Lymphedema? _____

Please list your hobbies and interests and if they have been affected by your Lymphedema: _____

Do you feel tired all the time? Yes | No

Has your Lymphedema affected any of your relationships? Yes | No

What are your expectations from your treatment? _____

Other concerns, comments, questions: _____

Patient's Signature: _____ Date: _____

Therapists Signature: _____ Date: _____

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AUM Bodyworks, LLC 1001 Cromwell Bridge Road, Suite 208
Scott Kover, NCMT, LLCC, RYT₂₀₀ Towson, MD 21286
410 321-0530 ext 2 Phone 410 707-6290 Mobile 410 321-0532 FAX

Massage Therapy, Reiki, Integrative Reflexology, Ear Candling, Yoga Instruction
Lymph Drainage Therapy, Complex Decongestive Physiotherapy for Lymphedema



Patient Release & Consent To Treatment

I personally or through my physician have requested treatment at AUM bodyworks. I hereby consent to receive such treatments as prescribed by my physician. AUM bodyworks shall have no liability, or continuing responsibility with respect to my condition, any changes therein or consequences of treatment or services rendered with respect to the necessity or appropriateness for such treatment and services. As I rely solely on my physicians advice and not on any statement or representations made by AUM bodyworks, its employees or agents, I hereby release AUM bodyworks and its affiliates from all liability for any misconceptions or misinformation I may have received. I also hereby release, waive and discharge for AUM bodyworks and its affiliates, their heirs, principals, agents, employees, executors, administrators, successors and assigns of any from any and all actions, causes of actions, damages or demands of whatsoever kind or character which the undersigned may hereafter on account of all injuries or injuries results direct or indirect arising or to arise and caused by or resulting from the provision of therapy to the undersigned. I hereby certify all of the information given by me in applying for treatment is true and correct. I hereby authorize the release of any medical records from any hospital, doctor or other medical agency or institution to AUM bodyworks as requested.

Signed: _____

Date: _____

I hereby release AUM bodyworks of all liability:

Name: _____

Date: _____

I hereby authorize the release of my medical records:

Name: _____

Date: _____

Witness: _____

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Lymphedema Treatment Consent

Name: _____ Referring Doctor: _____

Successful treatment of Lymphedema requires commitment and dedication of the patient and therapist to the therapy program. Please understand that this program is *not* a cure but a maintenance program. You will be responsible for keeping your condition under control the rest of your life. Reduction of edema not only improves the quality of your life, but also decreases the incidence of severe secondary infections. If you are treated at AUM bodyworks you will be required to follow a specific program at the office and at home.

This program consists of:

1. Daily/weekly visits for evaluation, treatment, and measurements by the therapist.
2. A meticulous skin care routine.
3. Massage/lymph drainage therapy, which may include the chest and groin.
4. Bandaging of the limb 20-23 hours a day.
5. Self-bandaging on weekends. (You and your family will be instructed in self-massage and self-bandaging.
6. Therapeutic exercises to accelerate lymph flow.
7. Instruction in a home maintenance program.

Bandages and garments (unless covered by your insurance company) need to be paid for in cash, k check or credit card.

Please note that non-compliance in the above outlined program may lead to discharge.

Are you prepared to follow such a program? Yes | No

This consent form has been explained to me and I certify that I fully understand its contents.

(Print Name)

(Patient's Signature)

(Date)

(Witness)

(Date)

AUM bodyworks

Patient Initial Evaluation

Name: _____ Date: _____

HOW DOES YOUR LIMB FEEL? On a scale of 0 to 5 where 0 means no sensation, 3 indicates no discomfort, 5 indicates unbearable.

- | | |
|-------------------------|-----------|
| Hot | 1 2 3 4 5 |
| Full | 1 2 3 4 5 |
| Numb | 1 2 3 4 5 |
| Hard | 1 2 3 4 5 |
| Heavy | 1 2 3 4 5 |
| Tired | 1 2 3 4 5 |
| Stiff | 1 2 3 4 5 |
| Achy | 1 2 3 4 5 |
| Painful | 1 2 3 4 5 |
| Tingles | 1 2 3 4 5 |
| Needles & Pins | 1 2 3 4 5 |
| Decreased function | 1 2 3 4 5 |
| Bursting sensation | 1 2 3 4 5 |
| Other (describe & rate) | 1 2 3 4 5 |

Does the way your limb looks embarrass you? Yes | No
 If yes, rate on a scale of 1 to 10 where 1 is minor embarrassment and 10 is extreme embarrassment:

1 2 3 4 5 6 7 8 9 10

What type of results do you expect from the therapy? (Circle all that apply)

- | | | |
|----------------------|----------------------|-------------------------------|
| No expectations | Not as hard | Able to wear regular clothing |
| Decreased size | Decreased infections | Limb will become "normal" |
| Close to normal size | Increased movement | |
| Other: _____ | | |


Release for Photographs

I HEREBY authorize AUM bodyworks to make and use any photographs, digital pictures, slides, and/or videotapes of me for educational purposes only. This authorization extends to copies of any said photographs, digital pictures, slides, and videotapes. I do not expect compensation of said photographs

Date: _____

Patient Signature: _____

Patient Printed Name: _____

Witness Signature: _____

Witness Printed Name: _____

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Records Release-Authorization to Pay Benefits To Provider-Payment Agreement

All information I disclose is confidential and protected by the therapist/patient relationship, except as authorized. I authorize AUM bodyworks to release the profile, reports, treatment notes and all other records requested by my health care provider, all attorneys and insurance carriers. AUM bodyworks is authorized to communicate directly with my health care provider regarding my treatment and care. If AUM bodyworks bills a carrier on my behalf, I authorize the carrier to make payment of medical benefits directly to AUM bodyworks. I fully understand and agree that I am legally responsible to AUM bodyworks for payment in full of all services rendered to me.

Signature: _____

Date: _____

Original to patient, copy in chart

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