CONFIDENTIAL

Lymphoedema Client Information Form

Patient Details

Surname: ..... Given Names: .....

Address: .....

Home Phone: ..... Mobile: ..... Date of birth: ..... /..... /.....

Email: .....

Emergency Contact Person: ..... Phone: .....

Health Fund

Health Fund? Yes/No Name of health fund: .....

Your General Health Details

Occupation: ..... Physical Related Job Duties: .....

Please indicate if you have had or presently have problems in any of the following areas:

Chronic Pain	Herpes	Blood Clots	Headaches
Dizziness	Shingles	Osteoporosis	Allergies
Cold/Fever	Eczema	TMJ Syndrome	Arthritis
Diabetes	Psoriasis	Neck/Spinal Injury	Epilepsy
High Blood Pressure	Skin Disorders	Loss of balance	Insomnia
Health Ailments	A.I.D.S	Numbness	Pregnancy
Kidney Ailments	Phlebitis	Fatigue	P.M.S Syndrome
Cancer	Varicose Veins	Depression	Sleep Disorders
Infectious Conditions	Joint Replacement	Nervousness	Surgery

Other conditions not listed: .....

Lymphoedema Details

What type of Lymphoedema has your Doctor diagnosed: .....

Diagnosis Date: ..... Did it appear suddenly or gradually? .....

Do you know the cause of the Lymphoedema? .....

What type of treatments have you received for your Lymphoedema to date and when were they administered?

Medication: .....

Combined Decongestive Therapy: .....

Compression Garments: .....

Pneumatic Pump: .....

Surgery: .....

Other: .....

Have you had an infection in your limbs (date)?

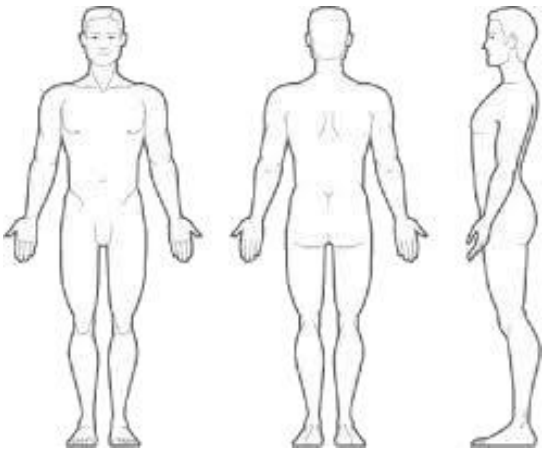
.....

Was it treated with antibiotics? Yes/No How long was the antibiotic treatment? .....

Have you noticed any changes in the following areas:

Skin: Yes/No Nails: Yes/No

Are any areas of your limbs noticeably harder than usual? Yes/No If yes, please indicate on diagram.



If you have an arm Lymphoedema, the therapist will need to work on the chest area in order to provide effective care. Do you consent to the treatment of your chest area? Yes/No

If you have leg Lymphoedema, the therapist will need to work on the upper medial thigh and buttock area. Do you consent to the treatment of these areas? Yes/No

Please sign and date the following statement: I confirm that all information provided here is true and that I have not omitted any information concerning my health. I accept full responsibility for advising the therapist of any changes to my medical circumstance when I visit in the future. I also give permission for my therapist to contact my referring medical doctor in reference to my Lymphoedema treatment.

Signature: ..... Date: .....

Guardian Signature: ..... Date: .....
(if client is under 18 years of age)

How did you hear about our Services? .....

Would you like to be added to our newsletter database? YES/NO