1. Please describe your current complaint or limitation: ________________________________
   ________________________________
   ________________________________

   1a. Lymphedema patients please describe your current swelling problem: ________________
   ________________________________
   ________________________________

2. What is your goal for therapy? __________________________________________________________
   ________________________________
   ________________________________

3. Have you received any previous PT, OT or Speech Therapy for any condition this calendar year?
   □ Yes □ No Comment: ________________________________________________________________
   ________________________________
   ________________________________

4. When did your problem begin? ____________ days ago ____________ months ago ____________ years ago
   Specific date, if possible: ________________________________

5. Since the onset of symptoms for which we will be treating you, what has been the worst level of symptoms
   you have experienced?
   (Circle the appropriate number below)
   
   0  1  2  3  4  5  6  7  8  9  10
   no symptoms          unbearable symptoms

6. What level are your symptoms right now? (Circle the appropriate number below)
   
   0  1  2  3  4  5  6  7  8  9  10
   no symptoms          unbearable symptoms

7. Please describe the nature of your symptoms:
   □ Sharp Pain       □ Numbness           □ Constant (76-100%)
   □ Dull ache        □ Tingling           □ Frequent (51-75%)
   □ Burning          □ Shooting           □ Occasional (26-50%)
   □ Throbbing        □ Other: ________________ □ Intermittent (25% or less)
Mark on pictures where you have symptoms:

8. Your symptoms are worse in:  
   - Morning
   - Afternoon
   - Night
   - Trying to sleep at night
   - Same all day

9. What makes your problem worse?  
   - Nothing
   - Sitting
   - Standing
   - Lying down
   - Movement/Exercise
   - Inactivity
   - Other ______________________

10. What makes your problem better?  
    - Nothing
    - Sitting
    - Standing
    - Lying down
    - Movement/Exercise
    - Inactivity
    - Other ______________________

11. If you have pain, what is your realistic expectation for pain levels upon completion of therapy?  
    - N/A
    - 0 no pain
    - 1 2 3 4 5 6 7 8 9 10 unbearable pain

12. At the present time, would you say that your health is excellent, very good, fair or poor?    ______________________

13. Occupation:  ______________________  
    - Full time
    - Part time

    Has your work status changed because of this condition?  
    - Yes  - No

14. What functional activities are you having difficulty doing or are you unable to do because of your symptoms?  
    ______________________
15. Have you in the past or do you now have any of the following?

- [ ] High Blood Pressure
- [ ] Heart Attack
- [ ] Diabetes
- [ ] Stroke
- [ ] Pacemaker
- [ ] Seizures
- [ ] Cancer (Location: ______________________)
- [ ] Arthritis
- [ ] Osteoporosis

- [ ] Asthma
- [ ] Child Birth (☐ Cesarean ☑ Vaginal)
- [ ] Drug or Alcohol Dependence
- [ ] Caffeine Drinks (_____ cups/cans per day)
- [ ] Tobacco Use (_____ packs per day)

16. Other Medical Diagnoses and Conditions:

________________________________________________________________________________________

17. Surgeries:

________________________________________________________________________________________

18. Allergies (Drug/Food/Environmental):

________________________________________________________________________________________

19. Current Medications and Supplements:

________________________________________________________________________________________

20. We will be educating you regarding your condition and to provide a home program. How do you learn best? 

- [ ] Doing/Participation
- [ ] Listening/Discussion
- [ ] Reading/Handouts
- [ ] Visual/Demonstration

21. Do you have any cultural or spiritual concerns that we should consider during your treatment?

________________________________________________________________________________________

22. Do you feel safe at home?  ☐ Yes  ☐ No

Thank you! Please turn this form in to the Outpatient Rehabilitation Check In Desk. Please also remember that a balanced diet is essential in the healing process and to maintain an active lifestyle.

Patient Signature: ___________________________ Date/Time: ___________________________