PHYSICAL THERAPY FOR WOMEN
Business Office
Phone: 817-247-1130
Fax: 817-292-7930

Treatment Locations:
Fort Worth
Dallas
Colleyville

BREAST LYMPHATIC DRAINAGE QUESTIONNAIRE

Current Complaint: _____
Onset:_____

Diagnostic Procedures Completed:

Thermagram	□ Yes □ No
Halo	□ Yes □ No
Screening Mamogram	□ Yes □ No
Diagnostic Mamogram	□ Yes □ No

Results of the above testing: _____
_____
_____

Are you having any:

Swelling	□ Yes □ No
Tenderness	□ Yes □ No
Changes skin temperature	□ Yes □ No
Changes in skin sensation	□ Yes □ No
Changes in skin color	□ Yes □ No
Changes in skin texture	□ Yes □ No
Scars	□ Yes □ No

Have you had any breast cysts? □ Yes □ No Where_____ How Many ____

Have you had breast cancer? □ Yes □ No
When _____
What Procedures were done?_____
_____

Have you had lymph nodes removed? □ Yes □ No Where_____ How Many ____

Do you have breast implants? □ Yes □ No What kind _____

Do you wear under-wire bras? □ Yes □ No

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INFORMED CONSENT FOR LYMPHATIC BREAST CARE

I understand that if I am referred to physical therapy for Lymphatic Breast Care. My healthcare practitioner has explained the purpose of lymphatic drainage of the breast and has answered all of my questions.

I understand the nature of the treatment and I give permission to Pamela N. Jones, M.S., PT, MT to perform Lymphatic Breast Care.

I understand that I am encouraged to give feedback to the therapist. I may discontinue the session at any time by verbally informing the therapist and the procedure will be discontinued and alternatives will be discussed with me..

Based on the information I have received from the therapist, I voluntarily agree to the standard assessment and treatment plans for my condition.

_____ _____

Patient's Signature date Therapist's signature.