**Lymphatic Therapy Services**

**Questionaire Fat Disorders**

 **Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Current weight:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight 1 year ago**

**The goal of my visit today:**

 To get or confirm a diagnosis Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 To get recommendations for medical treatment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If you have pain, on a 0-10 scale with 0=no pain and 10=the worst pain ever please fill out the following**:

My average daily pain is: \_\_\_\_\_\_\_\_\_\_

Highest level of my pain is: \_\_\_\_\_\_\_\_\_\_ Lowest level of my pain is: \_\_\_\_\_\_\_\_\_\_

The pain I am describing is in my: Head Eyes Muscles Fat Arms Lipomas

(check all that apply) Ribs Stomach Back Legs Feet Joints

**Diet**

Average daily calories: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of meals per day: 1 2 3 4 5 6 or more

Number of snacks per day: 1 2 3 4 5 6 or more

Bread servings/slices per day: \_\_\_\_\_\_\_\_\_; type of bread **-**  white wheat rye gluten-free tortilla

Servings of meat per day: \_\_\_\_\_\_\_\_; type of meat - fish chicken beef pork turkey

Servings of fruit per day: 1 2 3 4 5 6 or more

Servings of vegetables a day: 1 2 3 4 5 6 or more

Servings of fried food a day: 1 2 3 4 5 6 or more

Oil used for any food preparation: olive canola corn, sunflower flax \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- |
|  **Review of Systems General**  | **Yes**  | **No**  |
| Unexplained weight loss  | If yes, amount:  |
| Unexplained weight gain  | If yes, amount:  |
| Flu-like symptoms  |
| Difficulty sleeping  |
| **Head Eyes Ears Nose Throat**  | **Yes**  | **No**  |
| Thick skull fat  | If yes, how long:  |
| Difficulty Swallowing  | If yes: solids liquids  |
| Mouth sores  |  blurry ↓ acuity poor night vision  |
| Neck feels swollen  |
| **Heart**  | **Yes**  | **No**  |
| Palpitations (pounding or irregular heart beat)  |
| Chest pain  |  at rest with activity  |
|  |
| **Dermatology**  | **Yes**  | **No**  |
| Easy bruising  |
| Itching  |  skin fat  |
| Water tricking under skin  |
| Burning sensations  |  skin fat feet fingers  |
| Scabs or lesions on head  |
| Scabs or lesions elsewhere  |
| **Endocrine**  | **Yes**  | **No**  |
| Fatigue: rate  | 1 2 3 4 5 6 7 8 9 10  |
| Low body temperature  | Typical temp:  |
| High body temperature  | Typical temp:  |
| Feel thirsty all the time  |
| Tremors  |  hands feet  |
| Hair loss  |  head underarms legs  |
| **Gastrointestinal**  | **Yes**  | **No**  |
| Bloating  |  after meals always  |
| Diarrhea  |
| Constipation  |
| Abdominal pain  |  inside in fat  |
| Nausea  |
| Vomiting  |
| Early satiety (fill up easily when eating)  |
| **Genitourinary**  | **Yes**  | **No**  |
| Pain with intercourse  |
| Bladder pressure and pain  |
| Nocturia (get up at night to urinate)  | How often: 1 2 3 4  |
| **Vascular**  | **Yes**  | **No**  |
| Water retention (weigh more at night)  |
| Blood clot in vein  |
| Swelling (edema)  |  pitting non-pitting  |
| Visible veins on legs  |
| Visible veins on arms  |
| **Infectious Disease**  | **Yes**  | **No**  |
| Cellulitis (infection of skin requiring antibiotics)  |
| Epstein barr virus titers high  | Value:  |
| Lyme’s disease  |
| Inflammation in blood (high ESR or CRP)  | Other:  |
|  |  |  |
|

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| --- | --- | --- |
| **Musculoskeletal/Rheumatology**  | **Yes**  | **No**  |
| Muscle aches  |  arms thighs back  | **COMPLETE NEXT PAGE →→→→→→→→→**  |
| Joint aches  |  elbows wrist knees hips  |
| Muscle weakness  |  arms legs trunk  |
| Arms or legs jerk (myoclonus)  |
| Low back pain  |
| Dry eyes  |
| Dry mouth |

 |  |
| **Neurology**  |  **Yes No**  |  |
| Vertigo (dizziness)  |
| Hearing loss  | How long:  |
| Headaches  |  migraine  |
| Numbness  |  arms abdomen legs feet  |
| Poor concentration/thinking  |
| **Pulmonary**  | **Yes**  | **No**  |
| Shortness of breath  | How long:  |
| Frequent congestion  |
| Sleep apnea  | Use CPAP at night: Yes No  |
| **Psychiatry**  | **Yes**  | **No**  |
| Depression  | How long:  |
| Anxiety  | How long: |

Darken in areas of lipomas. Mark numb areas (∅∅∅)

Mark pain areas as follows: Stabbing pain (^^^); burning pain (∼∼∼)

