Radiant Heart Wellness Studio

Health Intake Form

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Suite A
Cockeysville, MD 21030

Name and pronoun:_____ Date of Birth: _____

Occupation: _____

Address _____

Referred By: _____ Phone: _____

Email: _____

Surgical Procedure(s) _____

Reason for Procedure (s)_____

Surgeon _____

Date of Surgery _____

Location of Surgery _____

Care and bodywork received if procedure was out of state_____

Current Complaints _____

_____

How much do you consume daily? Water _____ Soda _____ Alcohol _____ Salt _____
Cigarettes_____

How much do you exercise currently?_____

Other info:

How do you feel like you looked before the procedure? (worse) 1 2 3 4 5 6 7 8 9 10 (best)

How do you feel like you look after the procedure? (worse) 1 2 3 4 5 6 7 8 9 10 (best)

How do you feel about your recovery up until this point? (worse) 1 2 3 4 5 6 7 8 9 10 (best)

Your feelings on how prepared you were (are) for the recovery phase (worse) 1 2 3 4 5 6 7 8 9 10 (best)

Amount of education you received before surgery (none) 1 2 3 4 5 6 7 8 9 10 (a lot)

Do you feel like you want more education regarding your surgery? **yes** **no**

How prepared do you feel mentally and emotionally for your surgery? (not at all) 1 2 3 4 5 6 7 8 9 10 (ready to go)

How prepared do you feel logistically for the surgery? (not at all) 1 2 3 4 5 6 7 8 9 10 (ready to go)

How supported do you currently feel regarding your surgery?(not at all) 1 2 3 4 5 6 7 8 9 10 (very supported)

Goals for the session:

Do you currently have (or have had a history) of the following medical problem conditions

	Yes	No	In the Past	Explain
Cardiac				
Lymphatic				
Diabetes				
Blood Clots				
Pregnancy				
Cancer				
Other				

Please circle and explain any of the listed conditions that apply to you (Currently or In the Past)	
Skin condition (acne, rash, fungal infection, current herpes outbreak, anything contagious, etc.)	Kidney or Liver Disorder (failure, fatty liver disease, hepatitis A B C, cirrhosis, etc.)
Lymphatic Condition (Cancer, node removal, Lipedema, etc.)	Bone Condition (osteoporosis, bone fractures, cancer, osteopenia, etc.)
Circulatory Condition (heart disease, high blood pressure, varicose veins, arrhythmia, thrombosis, arteriosclerosis, pacemaker, stint, shunt, blood clot, stroke, etc.)	Neurological Condition (sciatica, numbness/tingling, Parkinson's, epilepsy, cognitive decline, dementia, Alzheimer's, etc.)
Autoimmune Disease (Lupus, Rheumatoid Arthritis, Multiple Sclerosis, Hashimoto's, etc.)	Mental Health Condition (depression, anxiety, bipolar, addiction, etc.)
Metabolic Condition (Diabetes, High cholesterol, Insulin resistance, PCOS, hyper or hypothyroidism, etc.)	Allergies
Neurodivergence (ADHD, Autism, Sensory Processing Conditions)	Cancer
Are there any accommodations or support needs that would help you access our services better today	Please list any other conditions that you are experience that could impact todays massage

Date: Signature