PACIFIC RECOVERY RETREAT

NEW CLIENT INTAKE & POST-OPERATIVE RECOVERY FORM

Please complete this form upon booking and return it to **info@pacificrecoveryretreat.com**. For questions, please contact **8181-938-3101**.

SECTION 1: GENERAL INFORMATION

Full Legal Name: _____

Date of Birth: _____ **Today's Date:** _____

Phone Number: _____

Email Address: _____

Home Address: _____

Post-Operative Recovery Address (if different): _____

Scheduled Surgery Date & Time: _____

Planned Procedure: _____

Surgeon's Name & Phone Number: _____

Surgery Center / Hospital: _____

Height: _____ **Weight:** _____

Preferred Language: _____

How did you hear about Pacific Recovery Retreat? _____

SECTION 2: EMERGENCY CONTACT

Full Name: _____

Relationship to Client: _____

Phone Number: _____

Secondary Emergency Contact (optional): _____

Phone Number: _____

SECTION 3: MEDICAL HISTORY

Previous Surgeries (include dates, if known):

Previous Significant Illnesses or Medical History:

Current Medical Conditions:

Current Medications (include dosage and frequency):

Preferred Pharmacy Name & Phone Number:

Medication Allergies (include reactions, if known):

Other Allergies (food, latex, adhesives, environmental, etc.):

Mobility Limitations or Assistive Devices Needed (walker, cane, wheelchair, etc.):

Other Physical Limitations or Special Accommodations:

SECTION 4: SURGERY & RECOVERY PLANNING

Have you received written post-operative instructions from your surgeon?

☐ Yes ☐ No ☐ Not yet

Will you provide your surgeon's post-operative instructions before care begins?

☐ Yes ☐ No ☐ Pending

Will a family member, friend, or caregiver be present during your recovery?

☐ Yes ☐ No

If yes, name and relationship: _____

Will you need assistance with mobility, dressing, bathing, meals, or other daily activities? Please specify.

Do you have any specific recovery needs, concerns, or accommodations you would like us to know about?

SECTION 5: SOCIAL HISTORY

Marital Status: _____

Occupation: _____

Do you own any pets? ☐ Yes ☐ No

If yes, what type and how many? _____

Do you consume caffeine? ☐ Yes ☐ No

If yes, amount and frequency: _____

Do you use tobacco or nicotine products? ☐ Yes ☐ No

If yes, type, amount, and frequency: _____

Do you consume alcohol? ☐ Yes ☐ No

If yes, amount and frequency: _____

SECTION 6: PERSONAL CONCERNS & ADDITIONAL INFORMATION

What are your biggest fears or concerns regarding your upcoming surgery or recovery?

Is there anything else you feel we should know to support your comfort, preferences, or recovery needs?

SECTION 7: CLIENT ACKNOWLEDGMENT

I confirm that the information provided in this form is accurate and complete to the best of my knowledge. I understand that this information helps Pacific Recovery Retreat assess and plan appropriate concierge nursing services. I agree to notify the nursing team of any changes to my health, medications, allergies, or recovery needs.

Client Signature: _____

Date: _____

Thank you for choosing Pacific Recovery Retreat. We look forward to providing personalized, attentive support throughout your recovery journey.

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