LEOPI NICOLA- INTAKE FORM FOR ORTHO-BIONOMY

Name_____

Address_____

Email_____

Phone_____

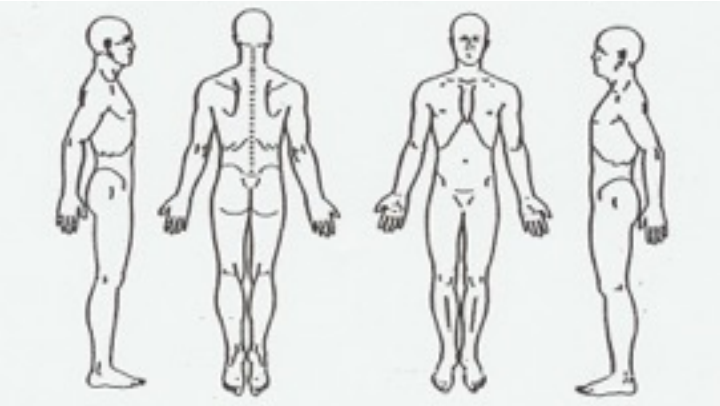
Date of birth_____

Occupation_____

Referrer_____

SHOW THE LOCATION OF PAIN

BRIEFLY GIVE HISTORY OF ILLNESS
ALSO INCLUDE SYMPTOMS.



_____

_____

_____

_____

_____

_____

_____

_____

Is the pain constant/intermittent?

_____

Does the pain radiate? Where?

_____

_____

What makes it feel better?

_____

_____

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What makes it feel worse?

_____

_____

Describe the pain:

_____

_____

Rate the pain intensity on a scale of 1-10 (10 the worst pain) 0 1 2 3 4 5 6 7 8 9 10 No pain Excruciating pain

Mark pain levels USING THE DIAGRAM AT TOP RIGHT

DULL ACHE BURNING

STABBING NUMBNESS

PINS & NEEDLES

Reason for today's visit?

_____

_____

When did it begin?

_____

_____

What makes it better?

_____

_____

What makes it worse?

_____

_____

Other therapies?

_____

PERSONAL STRESSORS AND EMOTIONAL STATE

Health challenges and illness sometimes manifest shortly after a major personal stress such as change in work or money status, moving, death or illness of a loved one, childbirth/miscarriage, separation/ divorce.

Has such an event occurred for you within the past: O 3 months O Longer

Please give details of how you feel this stressor has impacted your life and health.

_____

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_____

_____

_____

_____

Please describe your current emotional state:

_____

What regular activities cause you stress?

_____

Typically, where do you hold stress?

_____

When stressed, how do you relax or settle yourself?

_____

What type of sleep do you normally have?

_____

TRAUMA AND HEALING HISTORY:

Please list any surgeries, broken bones, accidents, etc (include dates):

_____

_____

_____

_____

OVERALL HEALTH:

Please list current medications (including herbs, homeopathic remedies, supplements, recreational drugs, nicotine, alcohol, and prescribed medications):

_____

_____

Are you currently under the care of a Physician/Nurse Practitioner/Mental Health Professional?

O Yes O No

_____

_____

Permission to consult with physician (if necessary)? Please initial if yes.

O Yes_____ O No _____

Anything else you want me to know?

_____

_____

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_____

_____

_____

_____

_____

_____

_____

I have stated all medical conditions of which I am aware and will inform my practitioner of any changes in my health status. By agreeing to work with me, you understand that you are fully responsible for your well being. Our work together is to enhance and support any processes you are involved in. I do not prescribe, diagnose or treat illnesses. Our work is not to replace seeing a physician. Your privacy is of the utmost importance to me. I do not share any information with anyone about you or our work together.

I certify that the information I have provided above is true and correct.

I understand that I am personally responsible for payment and that the fees are due and payable at the time of service. I will pay the agreed amount of time by the hourly rate in the form of cash or check or credit card at the time of service. If it is by credit card, Leopi is allowed to add a 5.00 fee for the transaction. There is a $5 fee for the use of all credit cards charged in my office. This is not the case if you pay online with PayPal, CASH or Venemo.

If I do not provide 24 hours notice by calling or texting (510)717-5060 or emailing Leopi @ info@sanctuaryleopi.com I will be responsible for the full price of the session.

Lastly, I agree to grant Leopi the right to cancel with less than 24-hour notice in the case of a personal emergency or Midwifery emergency or illness. In this case, she will notify me with as much advance notice as possible by, if necessary, both phone and email. Further, she will make every attempt to reschedule my session at our earliest convenience.

Signature:_____

Date:_____

I am honored to be working with you. Many thanks for choosing my services.