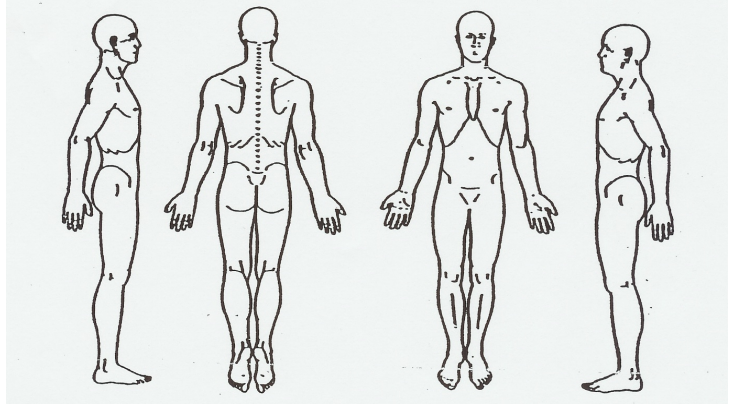


Leopi Nicola ~ Licensed Midwife
Ortho-Bionomy Intake Form
Ortho-Bionomy Intake Form

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?

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

USING THE DIAGRAM AT TOP RIGHT

DULL ACHE BURNING

STABBING NUMBNESS

PINS & NEEDLES

Leopí Nicola ~ Licensed Midwife

Ortho-Bionomy Intake Form

Reason for today's visit? _____

When did it begin? _____

What makes it better?

What makes it worse?

Other therapies?

Please mark where pain is and from 1 through 10 mark intensity of pain.

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: 3 months Longer

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

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?

Yes No

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

Yes _____ No

Leopi Nicola ~ Licensed Midwife
Ortho-Bionomy Intake Form

Is there anything else you want me to know? _____

I have stated all medical conditions of which I am aware and will inform my practitioner of any changes in my health status.

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 full rate of the session agreed upon at the time of service. If I do not provide 24 hours notice by calling 510 717-5060 or emailing leopi at leopinicola.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.

Signature Leopi SE _____

Date: _____