

Client Intake and Personal Data Form

Name _____

Address _____

Email _____

Phone _____

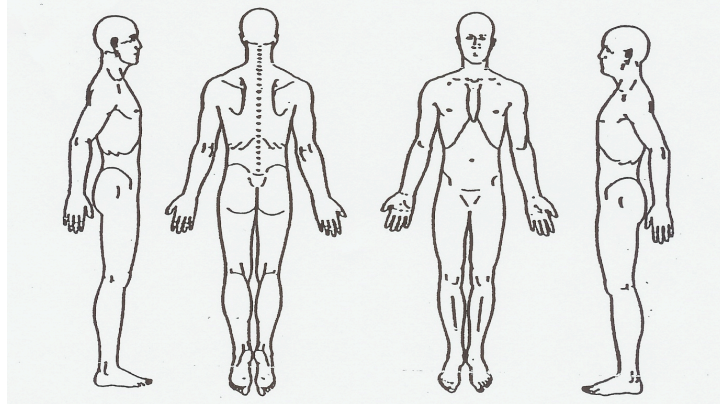
Date of Birth _____

Occupation _____

Referrer _____

BRIEFLY GIVE HISTORY OF ILLNESS, ALSO INCLUDE SYMPTOMS

SHOW LOCATION OF ANY PAIN YOU ARE EXPERIENCING



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

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

Is the pain a 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: 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
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 \$85-100.00, (or as agreed:_____) for a one hour treatment in the form of cash or check at the time of service. If I do not provide 24 hours notice by calling (510) 717-5060 or emailing Leopi at leopi@leopinicola.com, I will be responsible to reimburse Leopi 50.00 for her loss of time and business. 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:_____

Practitioner Signature:_____

Date:_____

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