



NOTE: All information will be kept confidential.

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex M / F

Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

E-mail (Bowenwork® Use Only) \_\_\_\_\_ Occupation \_\_\_\_\_

Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

Sports & Hobbies \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_ Referred by \_\_\_\_\_

Dominant Hand L / R \_\_\_\_\_

Date: \_\_\_\_\_

Please check all that apply:

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Abdominal / digestive problems | <input type="checkbox"/> Constipation                  | <input type="checkbox"/> Hip replacement                | <input type="checkbox"/> Pelvic pain                  |
| <input type="checkbox"/> Acid reflux                    | <input type="checkbox"/> Depression                    | <input type="checkbox"/> HIV/AIDS                       | <input type="checkbox"/> Plantar Fasciitis or Neuroma |
| <input type="checkbox"/> ADD                            | <input type="checkbox"/> Diabetes                      | <input type="checkbox"/> Hyperactivity                  | <input type="checkbox"/> PMS or Menopause             |
| <input type="checkbox"/> Allergies / hay fever          | <input type="checkbox"/> Diaphragm pain or tightness   | <input type="checkbox"/> Incontinence / bladder (adult) | <input type="checkbox"/> Pregnancy                    |
| <input type="checkbox"/> Ankle problems                 | <input type="checkbox"/> Diarrhea                      | <input type="checkbox"/> Infertility                    | <input type="checkbox"/> Prostate problem             |
| <input type="checkbox"/> Anxiety                        | <input type="checkbox"/> Dizziness                     | <input type="checkbox"/> Insomnia                       | <input type="checkbox"/> Rib pain / subluxation       |
| <input type="checkbox"/> Arthritis                      | <input type="checkbox"/> Ear or eye problems           | <input type="checkbox"/> Jaw surgery                    | <input type="checkbox"/> Sacral pain                  |
| <input type="checkbox"/> Asthma                         | <input type="checkbox"/> Eczema                        | <input type="checkbox"/> Jaw / TMJ problem              | <input type="checkbox"/> Sciatica                     |
| <input type="checkbox"/> Back pain                      | <input type="checkbox"/> Edema, general                | <input type="checkbox"/> Joint replacement              | <input type="checkbox"/> Scoliosis                    |
| <input type="checkbox"/> Bed wetting (children)         | <input type="checkbox"/> Elbow pain, tennis or golf    | <input type="checkbox"/> Knee problems                  | <input type="checkbox"/> Shin splints                 |
| <input type="checkbox"/> Bone spurs                     | <input type="checkbox"/> Fibromyalgia or Polymyalgia   | <input type="checkbox"/> Liver problems                 | <input type="checkbox"/> Shoulder problems            |
| <input type="checkbox"/> Breast lump                    | <input type="checkbox"/> Fibroids                      | <input type="checkbox"/> Lung problem                   | <input type="checkbox"/> Sinus problems               |
| <input type="checkbox"/> Breast pain                    | <input type="checkbox"/> Fracture                      | <input type="checkbox"/> Magnet usage                   | <input type="checkbox"/> Skin infection               |
| <input type="checkbox"/> Breast / Pectoral implants     | <input type="checkbox"/> Gallbladder problems          | <input type="checkbox"/> Migraines                      | <input type="checkbox"/> Sleep / energy problems      |
| <input type="checkbox"/> Bronchitis                     | <input type="checkbox"/> Hammer Toes                   | <input type="checkbox"/> Multiple Sclerosis             | <input type="checkbox"/> Stress                       |
| <input type="checkbox"/> Bunion                         | <input type="checkbox"/> Hamstring pain or tightness   | <input type="checkbox"/> Nausea                         | <input type="checkbox"/> Tailbone / Coccyx injury     |
| <input type="checkbox"/> Buttock pain                   | <input type="checkbox"/> Headaches                     | <input type="checkbox"/> Neck pain                      | <input type="checkbox"/> Tinnitus                     |
| <input type="checkbox"/> Cancer                         | <input type="checkbox"/> Heart problems                | <input type="checkbox"/> Numbness                       | <input type="checkbox"/> Uterine / Ovary problem      |
| <input type="checkbox"/> Carpal tunnel syndrome         | <input type="checkbox"/> Heating pad / ice pack usage  | <input type="checkbox"/> Orthodontia                    | <input type="checkbox"/> Wrist or Thumb pain          |
| <input type="checkbox"/> Chest pain                     | <input type="checkbox"/> Heating / cooling salve usage | <input type="checkbox"/> Orthotics in shoes             | <input type="checkbox"/> Other (please explain)       |
| <input type="checkbox"/> Chronic fatigue syndrome       | <input type="checkbox"/> Hernia                        | <input type="checkbox"/> Osteoporosis                   | _____   |
| <input type="checkbox"/> Colic (baby)                   | <input type="checkbox"/> Hip pain                      | <input type="checkbox"/> Pain (mark on next page)       | _____   |

Have you received Bowenwork before? Y / N \_\_\_\_\_

How did you hear about the Bowenwork? \_\_\_\_\_

What are your current health issues? \_\_\_\_\_

How long have you had these conditions? \_\_\_\_\_

What are your other top health concerns? \_\_\_\_\_

What medications are you currently taking and why? \_\_\_\_\_

Previous and recent hands-on modalities received: \_\_\_\_\_

What are your goals for today's visit? \_\_\_\_\_

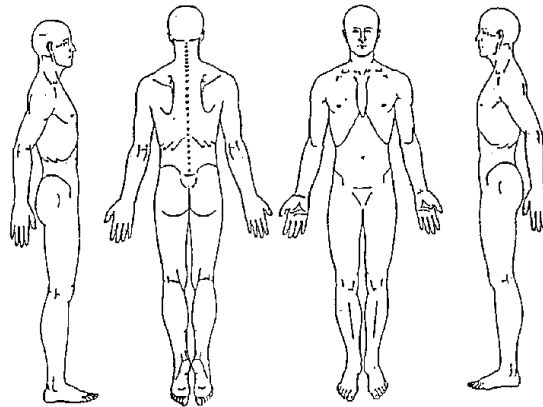
Please list all accidents, injuries, surgeries and falls that you can remember with dates of occurrence:

List activities compromised by condition (s): \_\_\_\_\_

Location of pain: indicate with X on the anatomical drawing at the site of pain and rate the severity of pain on a scale of 1 – 10. (can be stated a range)

Pain Intensity Scale - Pain is described as:

- (2) Mild Pain (annoying, nagging)
- (4) Discomforting (troublesome, numbing)
- (6) Distressing (miserable, agonizing, gnawing)
- (8) Intense (cramping, dreadful, horrible)
- (10) Excruciating (tearing, crushing, unbearable)



List current therapies \_\_\_\_\_

*I have read the above information and have stated all my known medical conditions. I understand that the therapy given here is for the purpose of stress reduction, relief from muscular tension or spasm, for facilitation circulation, energy flow or relief from stiff joints. I understand that I will be touched during a Bowenwork session. I understand that the therapist does not diagnose illness, disease, or any other physical or mental disorder. I take it upon myself to update my therapist regarding any changes in my condition. Everybody responds differently to Bowenwork. They respond in their own time and according to their own body's ability to heal.*

Signature \_\_\_\_\_ Date \_\_\_\_\_