

# Bowen Works Wellness

## Bowenwork® Intake Form

Name \_\_\_\_\_ DOB \_\_\_\_\_ M / F \_\_\_\_\_

Address \_\_\_\_\_

E-mail (Bowenwork use only) \_\_\_\_\_

Phones (h) \_\_\_\_\_ (w) \_\_\_\_\_ (c) \_\_\_\_\_

Occupation \_\_\_\_\_ Sports, hobbies \_\_\_\_\_

Emergency contact \_\_\_\_\_ Referred by \_\_\_\_\_

**Please check all that apply:**

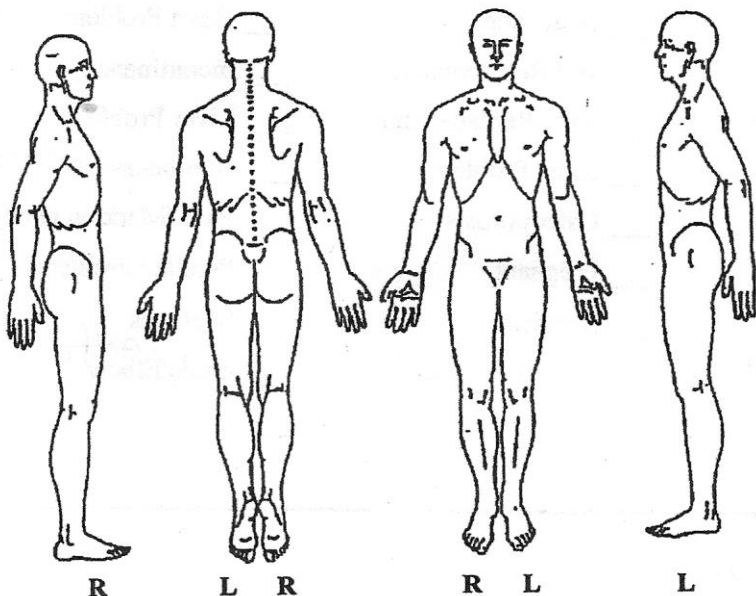
- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Chest pain                        | <input type="checkbox"/> Hamstring pain or tightness     | <input type="checkbox"/> Pain, other -- (location):<br>_____ |
| <input type="checkbox"/> Abdominal / digestive problem     | <input type="checkbox"/> Colic (baby)                    | <input type="checkbox"/> Headaches                           |
| <input type="checkbox"/> Allergies / hay fever             | <input type="checkbox"/> Constipation                    | <input type="checkbox"/> Heart problem                       |
| <input type="checkbox"/> Arthritis -- (location):<br>_____ | <input type="checkbox"/> Diabetes                        | <input type="checkbox"/> Hernia                              |
| <input type="checkbox"/> Asthma                            | <input type="checkbox"/> Diaphragm pain or tightness     | <input type="checkbox"/> Hip pain                            |
| <input type="checkbox"/> Ankle problem                     | <input type="checkbox"/> Diarrhea                        | <input type="checkbox"/> Hip replacement                     |
| <input type="checkbox"/> Back pain -- (location):<br>_____ | <input type="checkbox"/> Dizziness                       | <input type="checkbox"/> Incontinence / bladder (adult)      |
| <input type="checkbox"/> Bed wetting (children)            | <input type="checkbox"/> Ear or eye problem              | <input type="checkbox"/> Infertility                         |
| <input type="checkbox"/> Bone spurs                        | <input type="checkbox"/> Edema, general                  | <input type="checkbox"/> Jaw / TMJ problem                   |
| <input type="checkbox"/> Breast lump                       | <input type="checkbox"/> Elbow pain, tennis or golf      | <input type="checkbox"/> Joint replacement                   |
| <input type="checkbox"/> Breast pain                       | <input type="checkbox"/> Fatigue, chronic                | <input type="checkbox"/> Knee problem                        |
| <input type="checkbox"/> Breast implants                   | <input type="checkbox"/> Fibromyalgia or polymyalgia     | <input type="checkbox"/> Liver problem                       |
| <input type="checkbox"/> Bronchitis                        | <input type="checkbox"/> Fibroids - (location):<br>_____ | <input type="checkbox"/> Lung problem                        |
| <input type="checkbox"/> Bunion                            | <input type="checkbox"/> Fracture                        | <input type="checkbox"/> Magnet usage                        |
| <input type="checkbox"/> Bursitis                          | <input type="checkbox"/> Fallen on tailbone / coccyx     | <input type="checkbox"/> Migraines                           |
| <input type="checkbox"/> Buttock pain                      | <input type="checkbox"/> Gall bladder problem            | <input type="checkbox"/> Numbness --(location):<br>_____     |
| <input type="checkbox"/> Cancer                            | <input type="checkbox"/> Heating pad / ice pack usage    | <input type="checkbox"/> Orthodontia, extensive              |
| <input type="checkbox"/> Carpal tunnel syndrome            | <input type="checkbox"/> Heating / cooling salve usage   | <input type="checkbox"/> Orthotics in shoes                  |
|  | <input type="checkbox"/> Hammer toes                     | <input type="checkbox"/> Osteoporosis                        |
|  |  | <input type="checkbox"/> PMS or menopause                    |
|  |  | <input type="checkbox"/> Plantar fasciitis or neuroma        |
|  |  | <input type="checkbox"/> Pregnancy                           |
|  |  | <input type="checkbox"/> Prostate problem                    |
|  |  | <input type="checkbox"/> Rib pain / subluxation              |
|  |  | <input type="checkbox"/> Sacral pain                         |
|  |  | <input type="checkbox"/> Sciatica                            |
|  |  | <input type="checkbox"/> Scoliosis                           |
|  |  | <input type="checkbox"/> Shin splints                        |
|  |  | <input type="checkbox"/> Shoulder problem                    |
|  |  | <input type="checkbox"/> Sinus problem                       |
|  |  | <input type="checkbox"/> Sleep / energy problem              |
|  |  | <input type="checkbox"/> Tinnitus                            |
|  |  | <input type="checkbox"/> Uterine or ovary problem            |
|  |  | <input type="checkbox"/> Wrist or thumb pain                 |
|  |  | <input type="checkbox"/> Other:                              |

**Describe your condition(s), including length of time experienced. Please list all accidents, injuries, surgeries and falls that might be relevant in any way; include dates of occurrence. Continue on next page:**

\_\_\_\_\_  
\_\_\_\_\_

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

Shade in the site(s) of pain on the anatomical drawing, and rate the severity of each pain on a scale of 1-10:



Neck ROM:
L
R
TMJ:
Shoulder ROM:
L
R

**Pain intensity scale –**

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

**Current medications (it is sufficient to state purpose, such as cholesterol, high blood pressure, osteoporosis):**

**Recent hands-on modalities received:** \_\_\_\_\_

*I have stated, to the best of my knowledge, my known medical conditions. I understand that Bowenwork is given for the purpose of stress reduction, relief from muscular tension and/or spasm, facilitation of circulation and energy flow, and relief from stiffness. I understand that the practitioner does not diagnose illness or disease, nor treat specific physical or mental disorders. I will inform my practitioner of any changes in my condition, and will contact my practitioner should I have any concerns.*

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

Print Name \_\_\_\_\_