

Bowenwork® Intake Form

Name _____ DOB _____
Address _____ CITY _____ ST _____ ZIP _____
Phone: (primary) _____ (alternate) _____
Occupation _____ Sports, hobbies _____
Emergency contact _____
How did you hear about Bowenwork? _____

Please check all that apply:

<input type="checkbox"/> Abdominal / Digestion	<input type="checkbox"/> Fibroids - (location):	<input type="checkbox"/> Joint replacement _____	<input type="checkbox"/> Rib
<input type="checkbox"/> Constipation / <input type="checkbox"/> Diarrhea	<input type="checkbox"/> Fracture (old ___ new ___)	<input type="checkbox"/> Liver problem	<input type="checkbox"/> Sinus problem
<input type="checkbox"/> Asthma	<input type="checkbox"/> Fallen on tailbone	<input type="checkbox"/> Lung problem	<input type="checkbox"/> Shoulder problem
<input type="checkbox"/> Breast lump/ Breast pain	<input type="checkbox"/> Gall bladder problem	<input type="checkbox"/> Numbness --(location):	<input type="checkbox"/> Tinnitus (ringing in ears)
<input type="checkbox"/> Breast implants	<input type="checkbox"/> Headaches/ <input type="checkbox"/> Migraines	_____	<input type="checkbox"/> Uterine or ovary problem
<input type="checkbox"/> Cancer / Chemo	<input type="checkbox"/> Heart problem	<input type="checkbox"/> Dental work	<input type="checkbox"/> Back problem
<input type="checkbox"/> Concussion	<input type="checkbox"/> Hernia	<input type="checkbox"/> Pelvic pain	CHILDREN / BABIES:
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Incontinence / bladder (adult)	<input type="checkbox"/> PMS/Menopause/Hot Flashes	<input type="checkbox"/> Bed wetting
<input type="checkbox"/> Ear problem / <input type="checkbox"/> Eye problem	<input type="checkbox"/> Infertility	<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Colic
<input type="checkbox"/> Swelling _____	<input type="checkbox"/> Jaw / TMJ problem	<input type="checkbox"/> Prostate problem	<input type="checkbox"/> Trouble breast feeding

Other: _____

Do you have any pain or difficulty eating? Y ___ N ___ Do you have any pain or difficulty going to the bathroom? Y ___ N ___

Do you go to the bathroom daily? Y ___ N ___

Reason for today's visit _____

Signature _____ Date _____

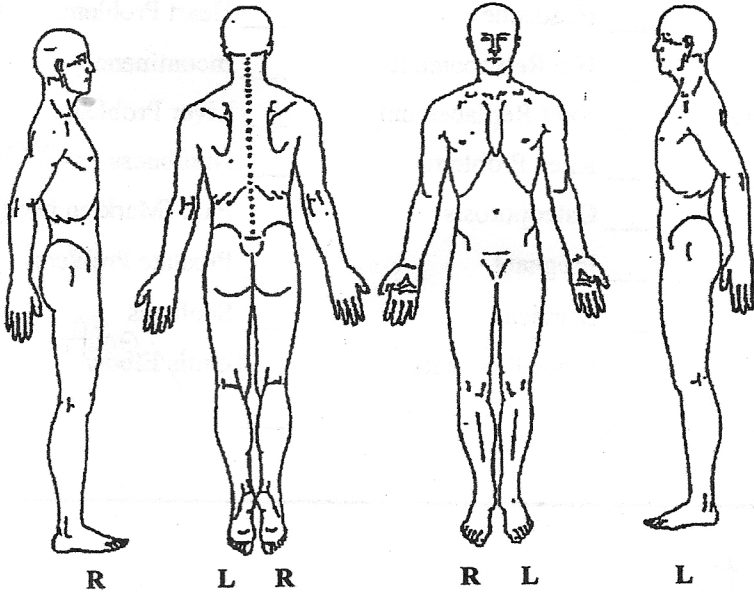
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Describe your condition(s), including length of time experienced. Please list all accidents, injuries, surgeries and falls that might be relevant in any way; include dates of occurrence.

Continue on back:

Are there things you can't do or stopped doing because of your condition?

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



Pain intensity scale –

- (2) Mild pain (annoying, nagging)
- (4) Discomforting (troublesome, numbing)
- (6) Distressing (miserable, agonizing, gnawing)
- (8) Intense (cramping, dreadful, horrible)
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Current medications (it is sufficient to state purpose, such as cholesterol, high blood pressure, osteoporosis):

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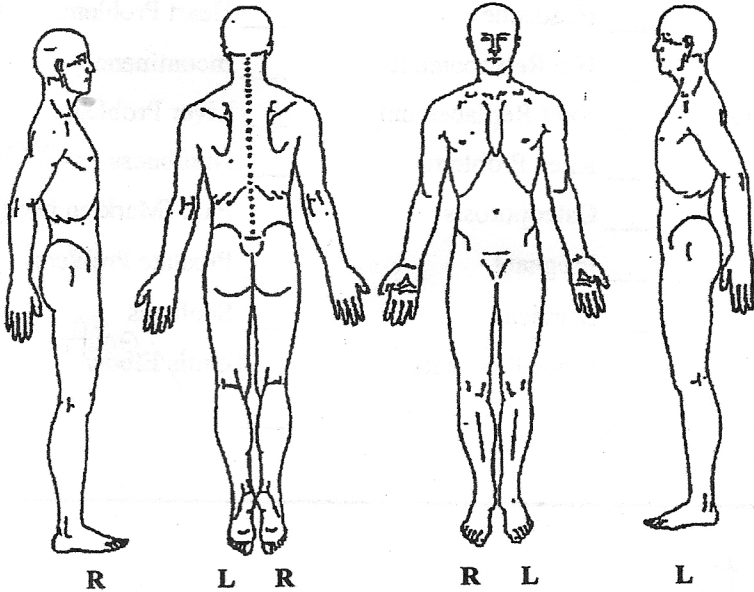
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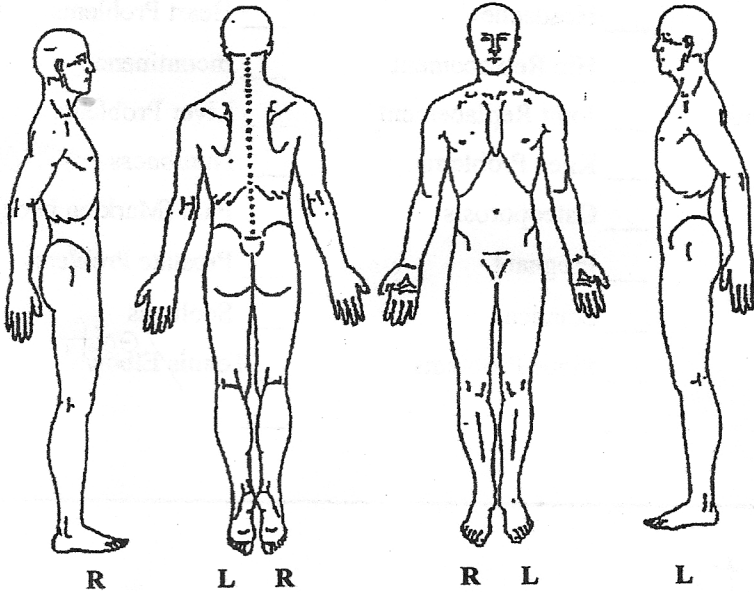
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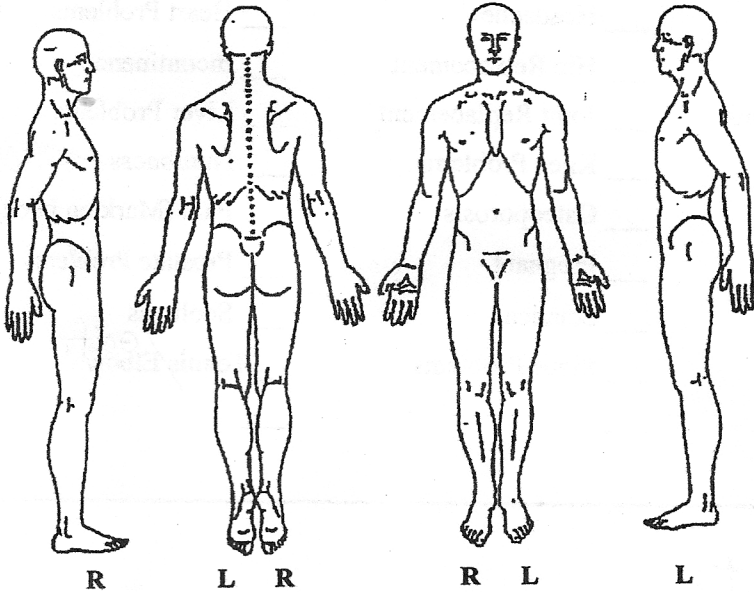
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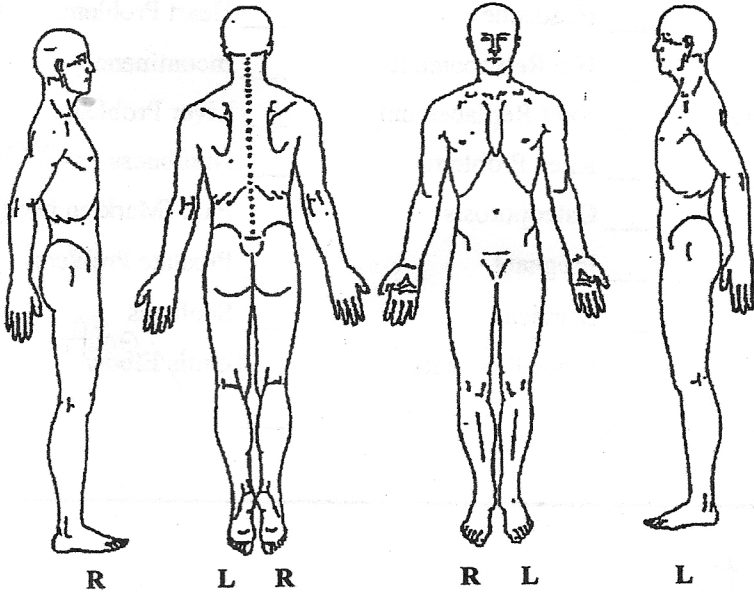
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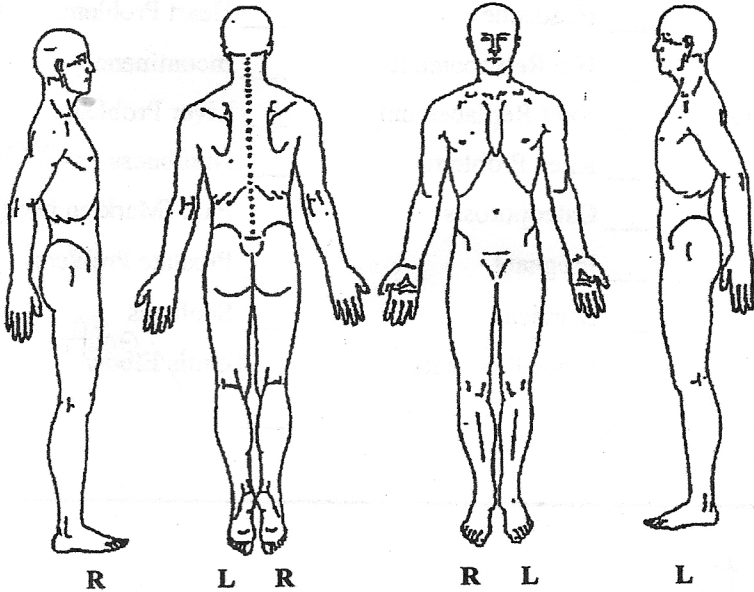
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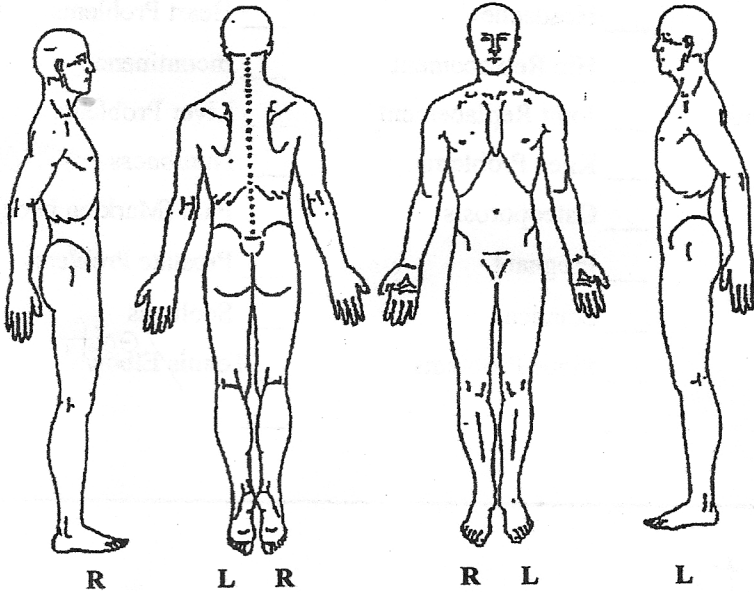
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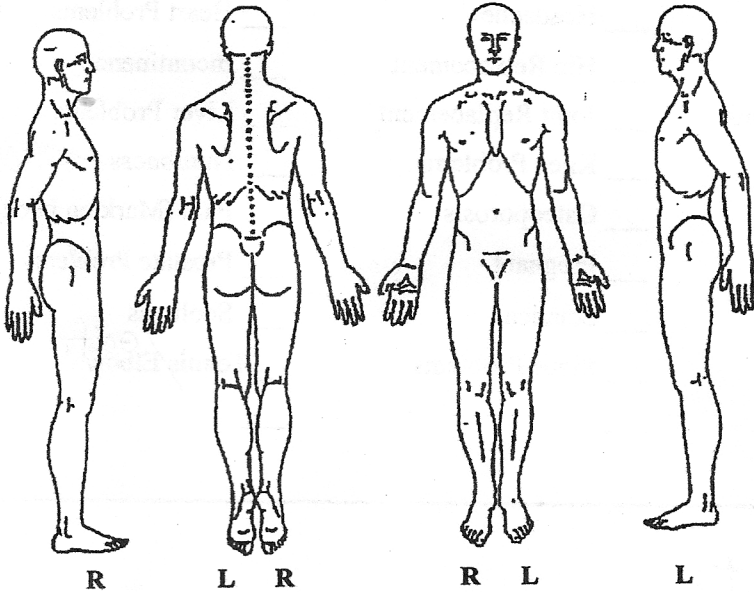
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<input type="checkbox"/> Constipation / <input type="checkbox"/> Diarrhea	<input type="checkbox"/> Fracture (old ___ new ___)	<input type="checkbox"/> Liver problem	<input type="checkbox"/> Sinus problem
<input type="checkbox"/> Asthma	<input type="checkbox"/> Fallen on tailbone	<input type="checkbox"/> Lung problem	<input type="checkbox"/> Shoulder problem
<input type="checkbox"/> Breast lump/ Breast pain	<input type="checkbox"/> Gall bladder problem	<input type="checkbox"/> Numbness --(location):	<input type="checkbox"/> Tinnitus (ringing in ears)
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<input type="checkbox"/> Swelling _____	<input type="checkbox"/> Jaw / TMJ problem	<input type="checkbox"/> Prostate problem	<input type="checkbox"/> Trouble breast feeding

Other: _____

Do you have any pain or difficulty eating? Y ___ N ___ Do you have any pain or difficulty going to the bathroom? Y ___ N ___

Do you go to the bathroom daily? Y ___ N ___

Reason for today's visit _____

Signature _____ Date _____

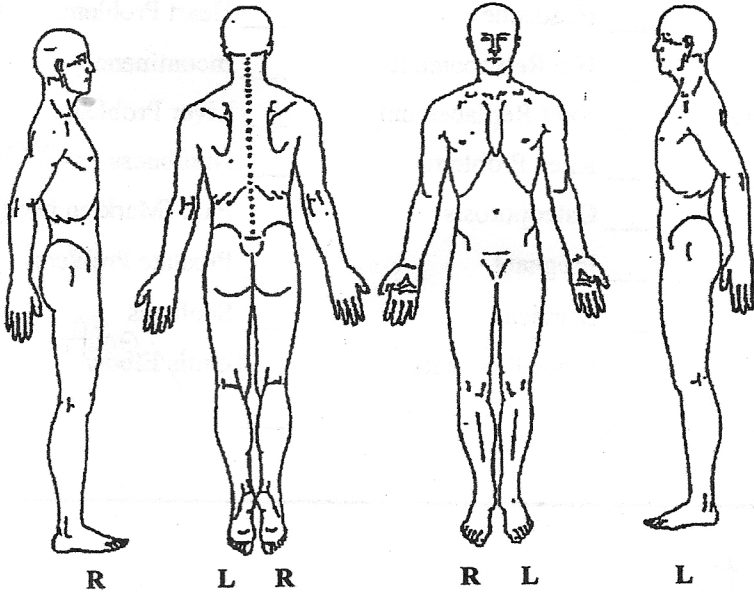
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Continue on back:

Are there things you can't do or stopped doing because of your condition?

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



Pain intensity scale –

- (2) Mild pain (annoying, nagging)
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- (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):

Notes:

Bowenwork® Intake Form

Name _____ DOB _____
Address _____ CITY _____ ST _____ ZIP _____
Phone: (primary) _____ (alternate) _____
Occupation _____ Sports, hobbies _____
Emergency contact _____
How did you hear about Bowenwork? _____

Please check all that apply:

- | | | | |
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Other: _____

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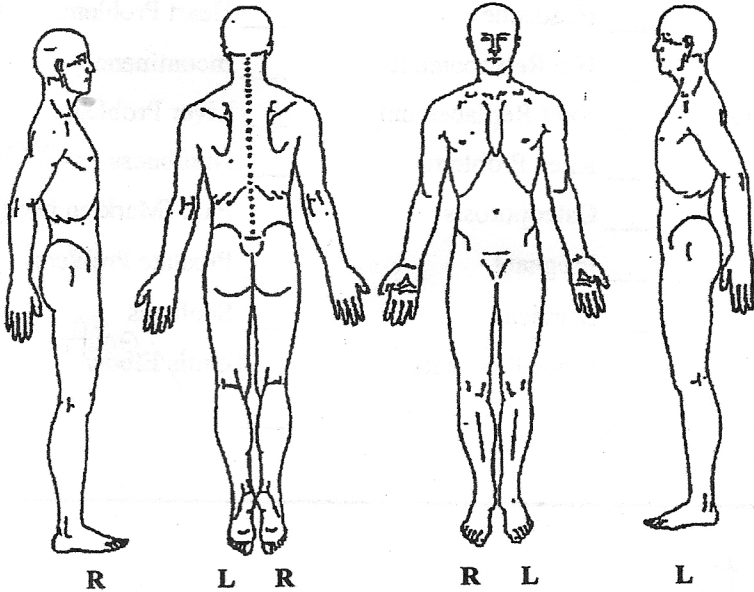
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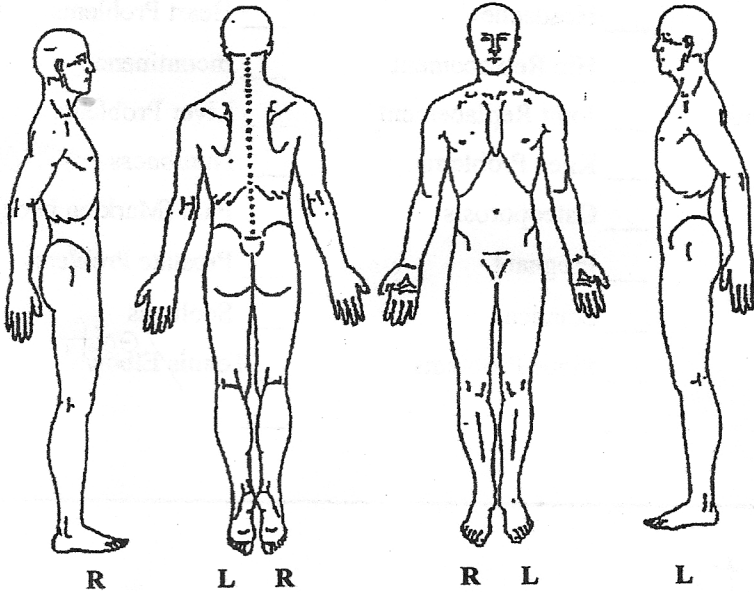
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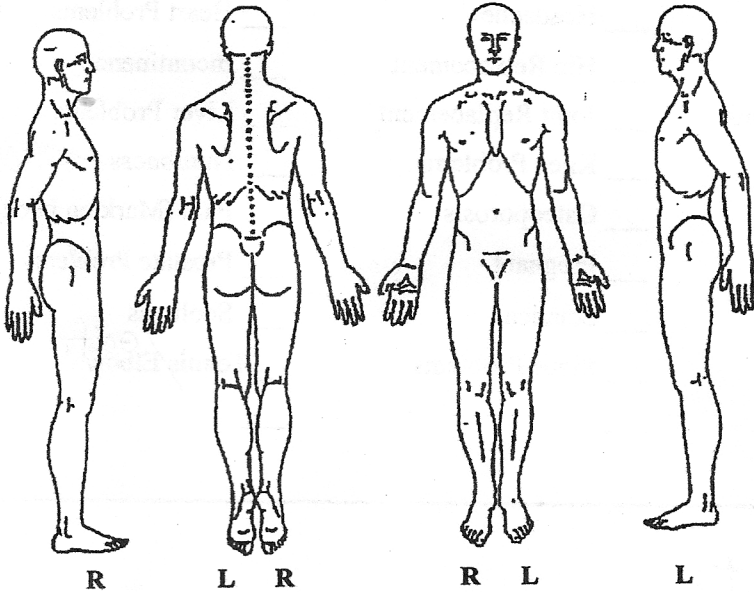
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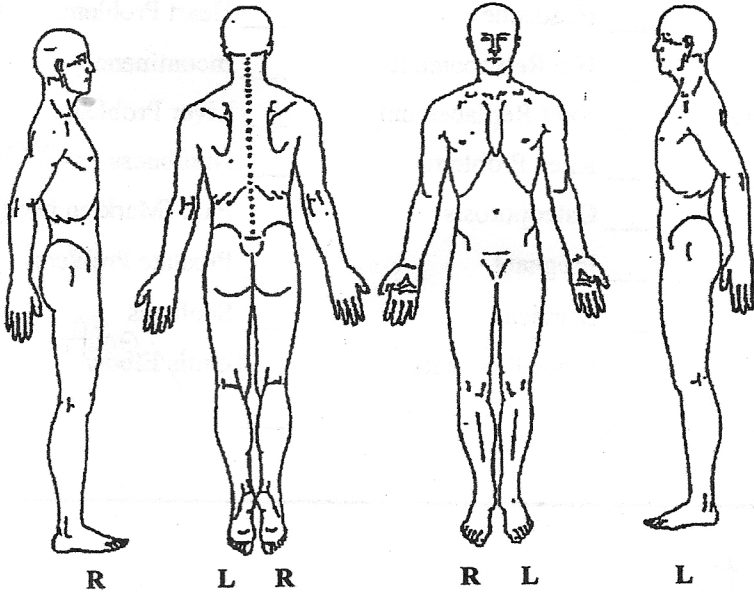
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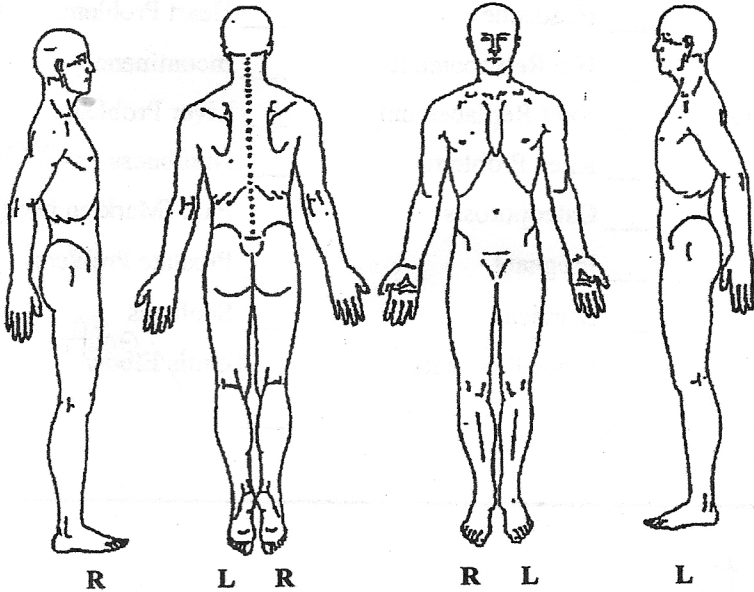
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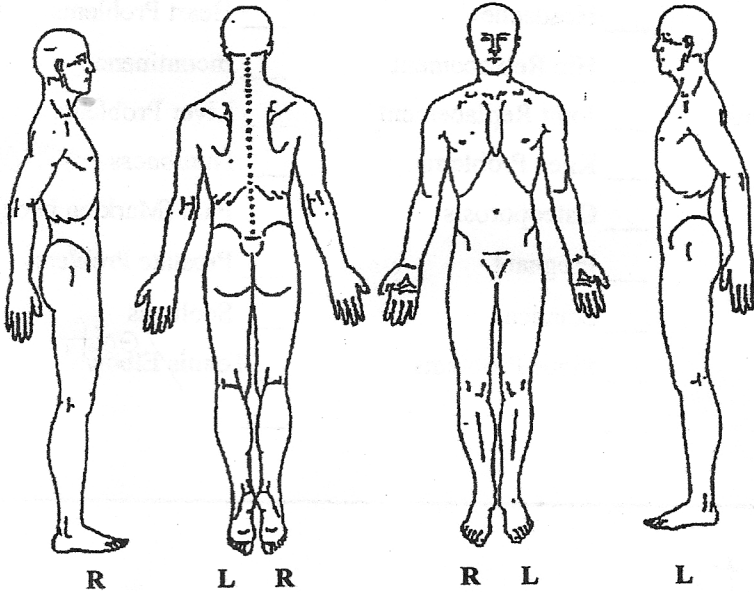
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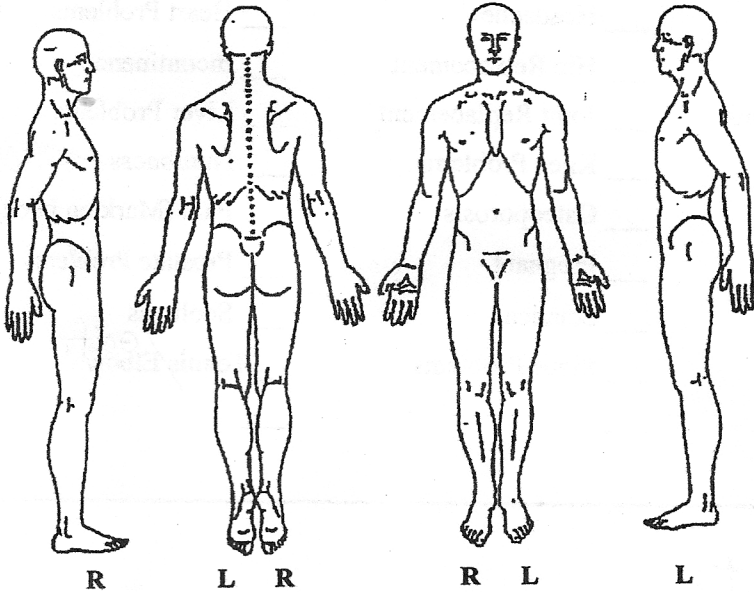
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<input type="checkbox"/> Asthma	<input type="checkbox"/> Fallen on tailbone	<input type="checkbox"/> Lung problem	<input type="checkbox"/> Shoulder problem
<input type="checkbox"/> Breast lump/ Breast pain	<input type="checkbox"/> Gall bladder problem	<input type="checkbox"/> Numbness --(location):	<input type="checkbox"/> Tinnitus (ringing in ears)
<input type="checkbox"/> Breast implants	<input type="checkbox"/> Headaches/ <input type="checkbox"/> Migraines	_____	<input type="checkbox"/> Uterine or ovary problem
<input type="checkbox"/> Cancer / Chemo	<input type="checkbox"/> Heart problem	<input type="checkbox"/> Dental work	<input type="checkbox"/> Back problem
<input type="checkbox"/> Concussion	<input type="checkbox"/> Hernia	<input type="checkbox"/> Pelvic pain	CHILDREN / BABIES:
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<input type="checkbox"/> Ear problem / <input type="checkbox"/> Eye problem	<input type="checkbox"/> Infertility	<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Colic
<input type="checkbox"/> Swelling _____	<input type="checkbox"/> Jaw / TMJ problem	<input type="checkbox"/> Prostate problem	<input type="checkbox"/> Trouble breast feeding

Other: _____

Do you have any pain or difficulty eating? Y ___ N ___ Do you have any pain or difficulty going to the bathroom? Y ___ N ___

Do you go to the bathroom daily? Y ___ N ___

Reason for today's visit _____

Signature _____ Date _____

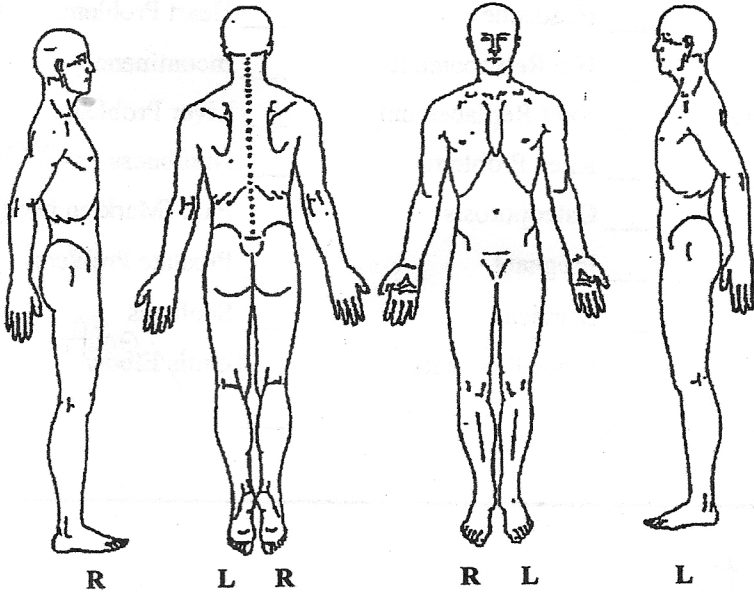
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Pain intensity scale –

- (2) Mild pain (annoying, nagging)
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- (10) Excruciating (tearing, crushing, unbearable)

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

Notes:

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Name _____ DOB _____
Address _____ CITY _____ ST _____ ZIP _____
Phone: (primary) _____ (alternate) _____
Occupation _____ Sports, hobbies _____
Emergency contact _____
How did you hear about Bowenwork? _____

Please check all that apply:

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Other: _____

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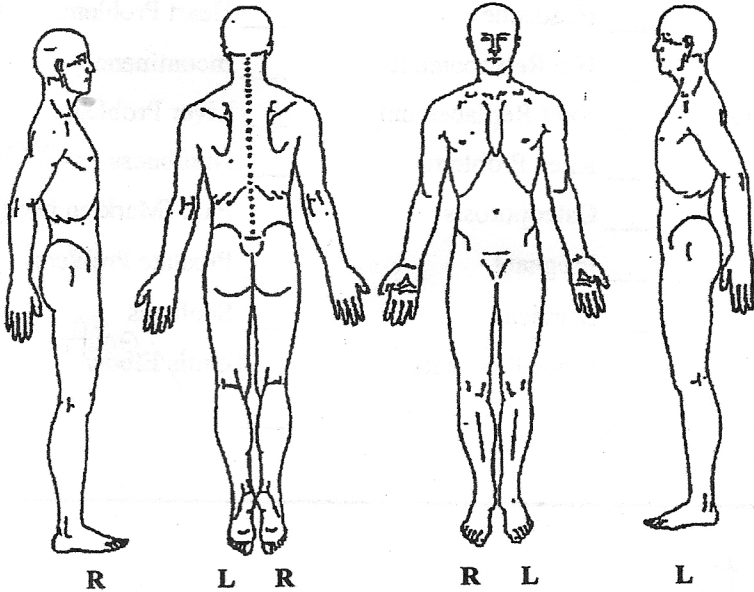
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Please check all that apply:

- | | | | |
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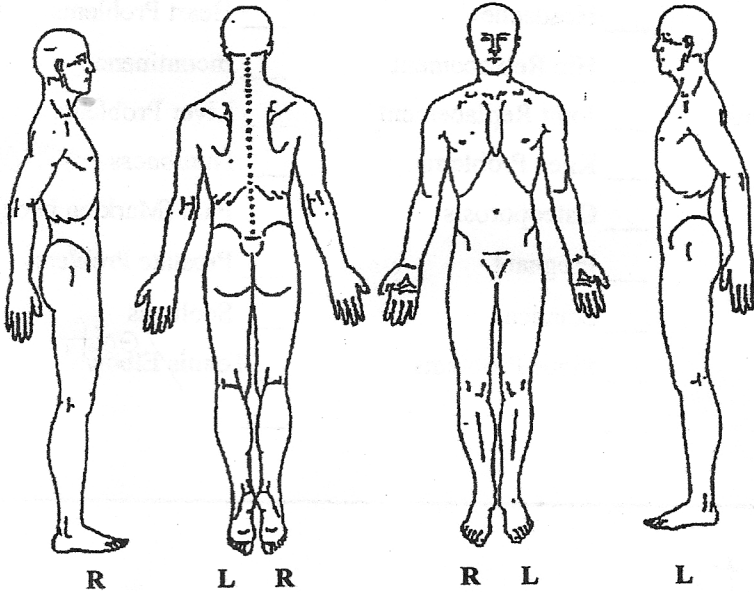
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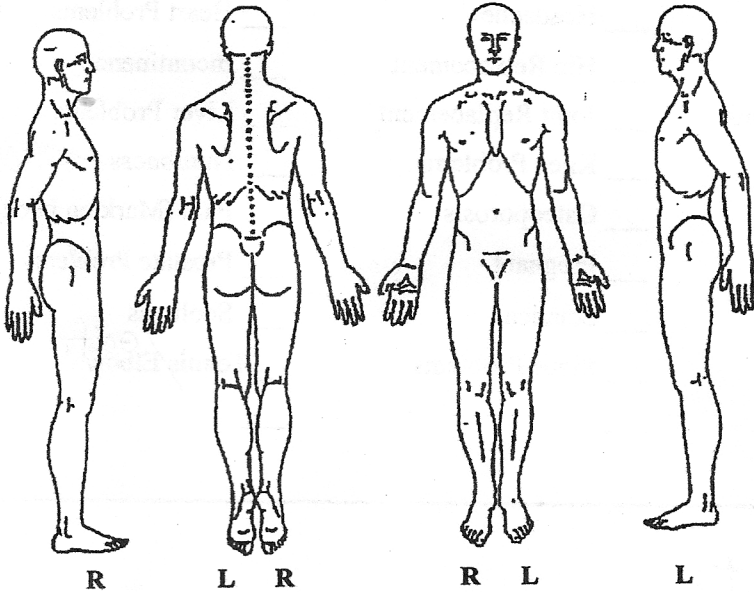
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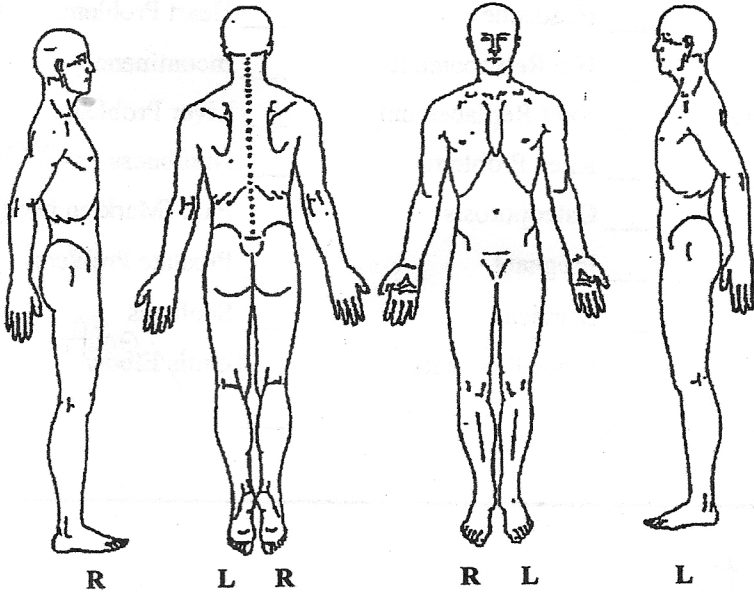
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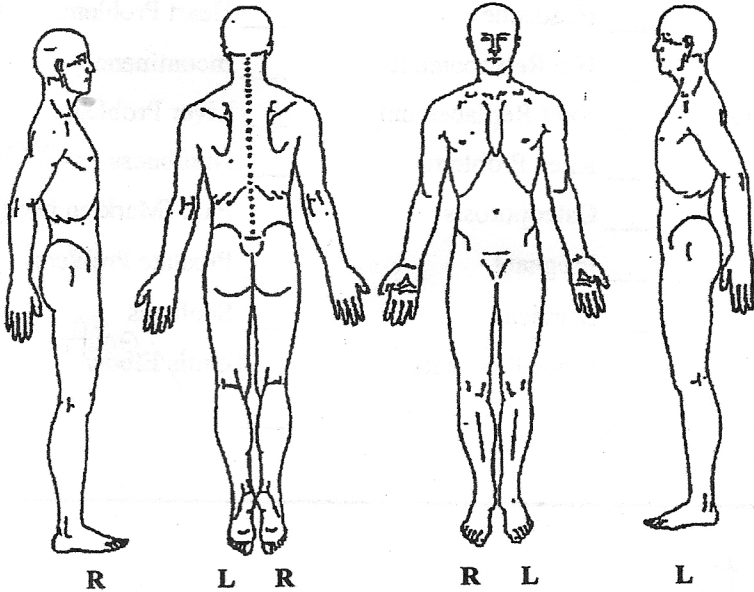
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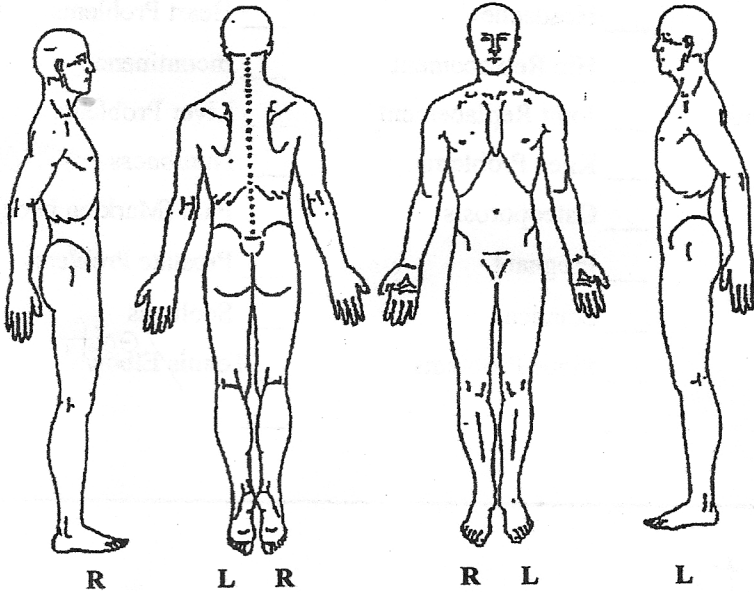
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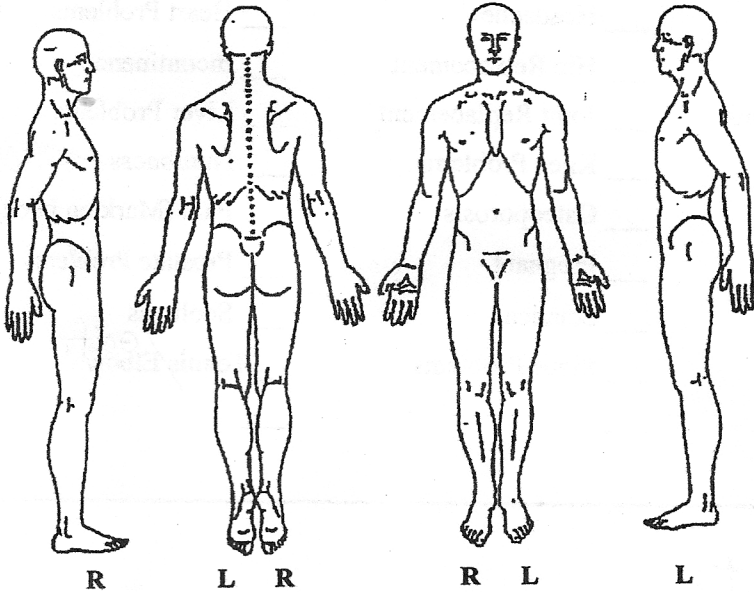
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<input type="checkbox"/> Breast lump/ Breast pain	<input type="checkbox"/> Gall bladder problem	<input type="checkbox"/> Numbness --(location):	<input type="checkbox"/> Tinnitus (ringing in ears)
<input type="checkbox"/> Breast implants	<input type="checkbox"/> Headaches/ <input type="checkbox"/> Migraines	_____	<input type="checkbox"/> Uterine or ovary problem
<input type="checkbox"/> Cancer / Chemo	<input type="checkbox"/> Heart problem	<input type="checkbox"/> Dental work	<input type="checkbox"/> Back problem
<input type="checkbox"/> Concussion	<input type="checkbox"/> Hernia	<input type="checkbox"/> Pelvic pain	CHILDREN / BABIES:
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Incontinence / bladder (adult)	<input type="checkbox"/> PMS/Menopause/Hot Flashes	<input type="checkbox"/> Bed wetting
<input type="checkbox"/> Ear problem / <input type="checkbox"/> Eye problem	<input type="checkbox"/> Infertility	<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Colic
<input type="checkbox"/> Swelling _____	<input type="checkbox"/> Jaw / TMJ problem	<input type="checkbox"/> Prostate problem	<input type="checkbox"/> Trouble breast feeding

Other: _____

Do you have any pain or difficulty eating? Y ___ N ___ Do you have any pain or difficulty going to the bathroom? Y ___ N ___

Do you go to the bathroom daily? Y ___ N ___

Reason for today's visit _____

Signature _____ Date _____

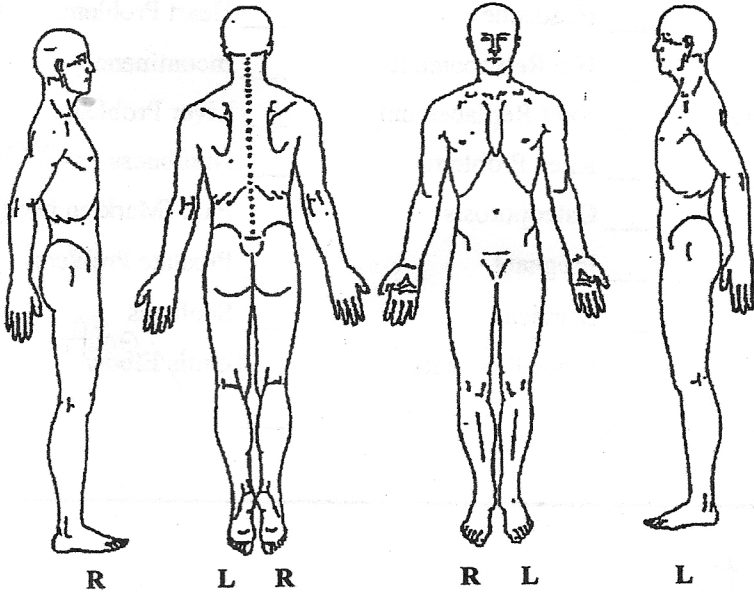
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Are there things you can't do or stopped doing because of your condition?

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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):

Notes:

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Name _____ DOB _____
Address _____ CITY _____ ST _____ ZIP _____
Phone: (primary) _____ (alternate) _____
Occupation _____ Sports, hobbies _____
Emergency contact _____
How did you hear about Bowenwork? _____

Please check all that apply:

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Other: _____

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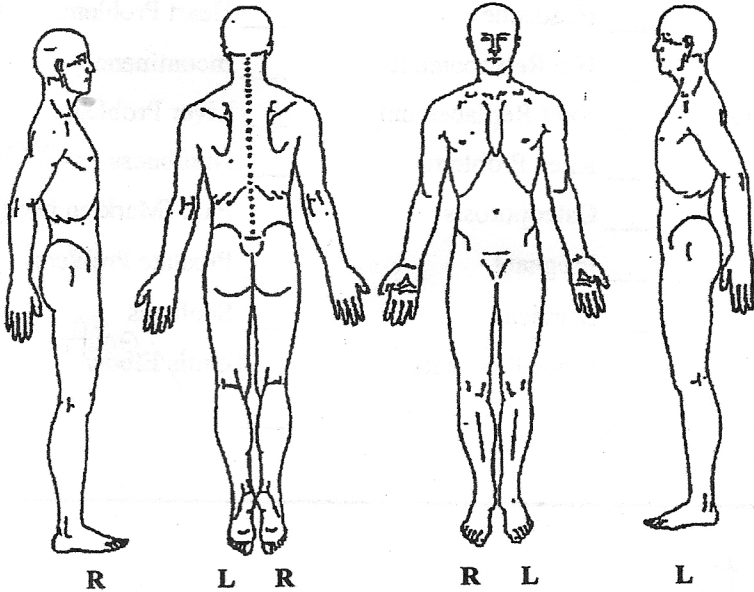
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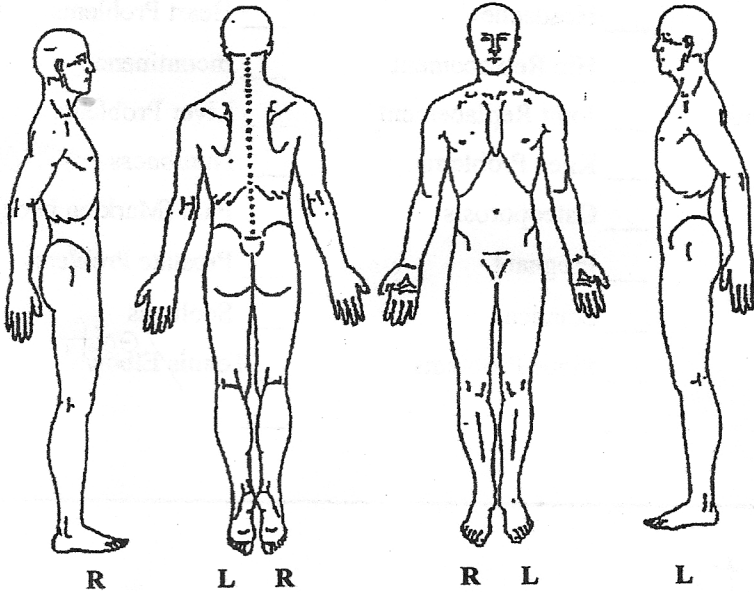
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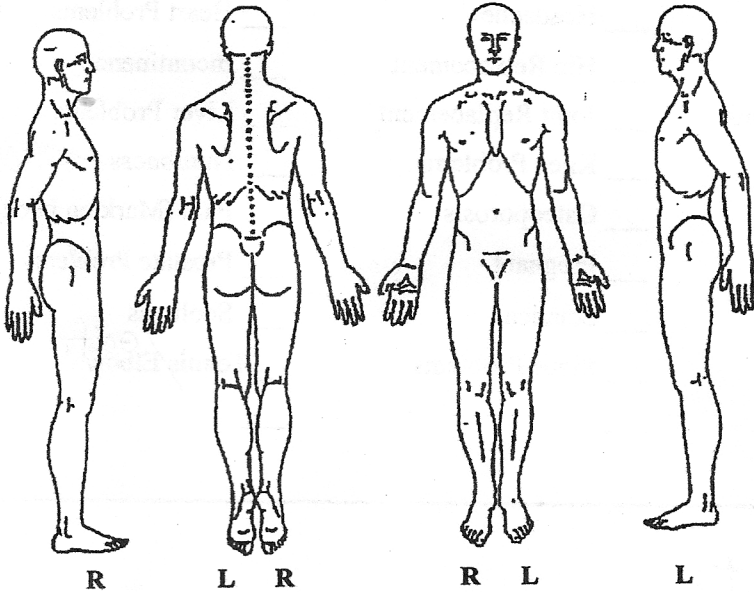
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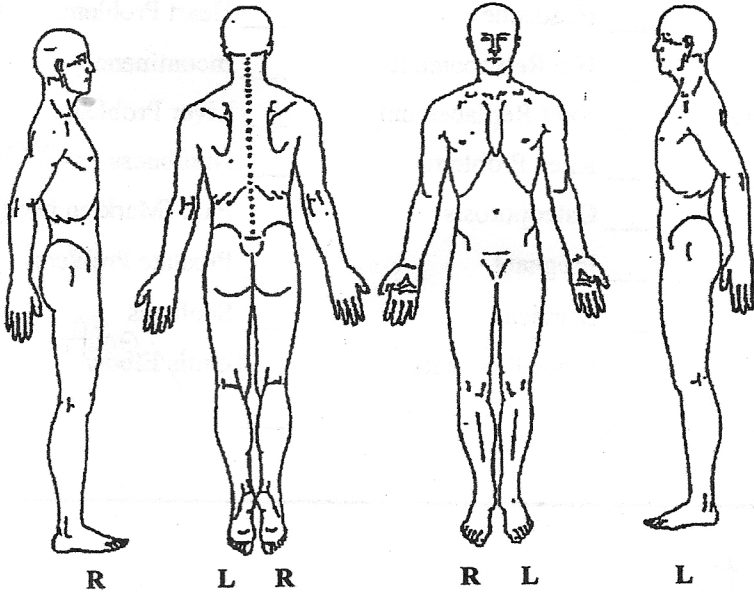
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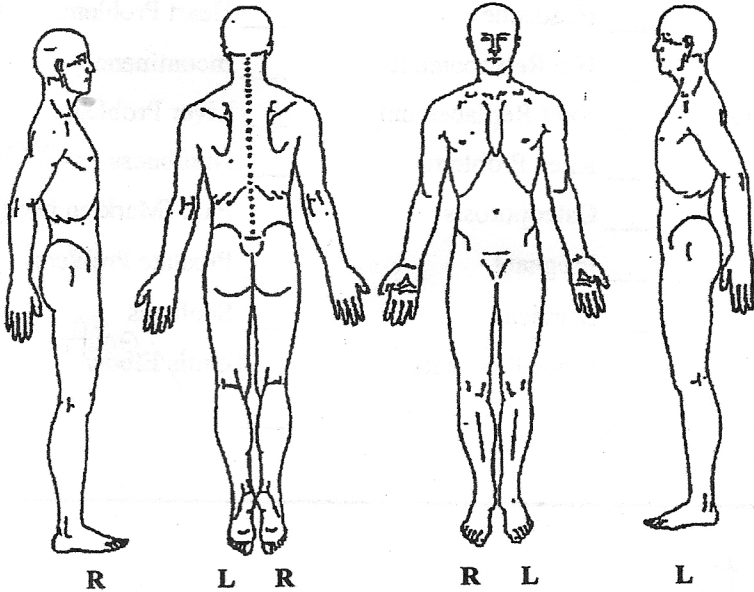
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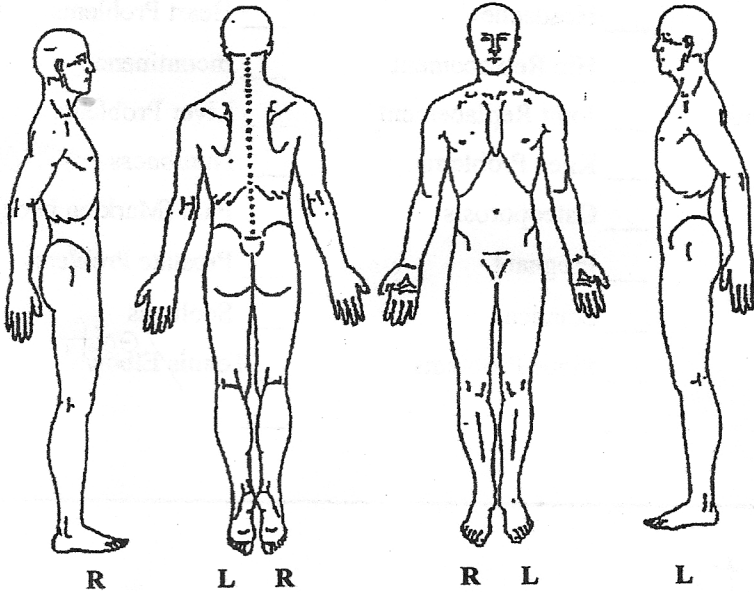
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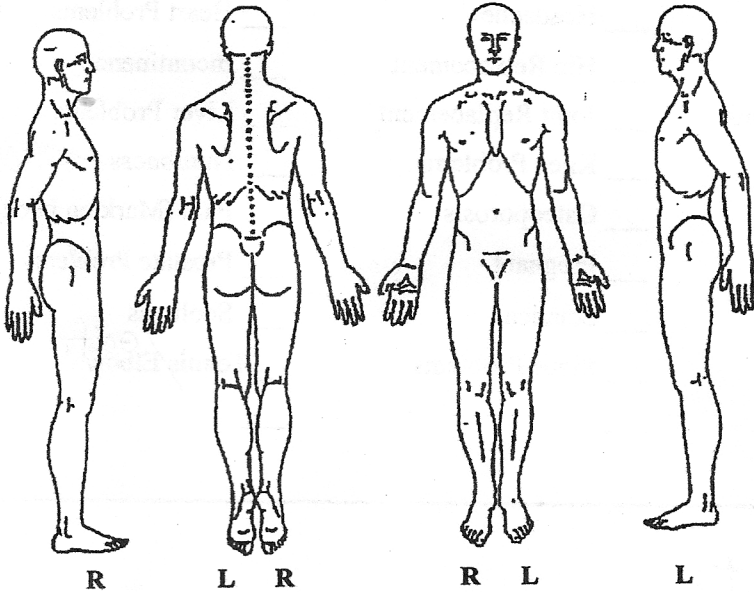
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<input type="checkbox"/> Breast implants	<input type="checkbox"/> Headaches/ <input type="checkbox"/> Migraines	_____	<input type="checkbox"/> Uterine or ovary problem
<input type="checkbox"/> Cancer / Chemo	<input type="checkbox"/> Heart problem	<input type="checkbox"/> Dental work	<input type="checkbox"/> Back problem
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<input type="checkbox"/> Dizziness	<input type="checkbox"/> Incontinence / bladder (adult)	<input type="checkbox"/> PMS/Menopause/Hot Flashes	<input type="checkbox"/> Bed wetting
<input type="checkbox"/> Ear problem / <input type="checkbox"/> Eye problem	<input type="checkbox"/> Infertility	<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Colic
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Other: _____

Do you have any pain or difficulty eating? Y ___ N ___ Do you have any pain or difficulty going to the bathroom? Y ___ N ___

Do you go to the bathroom daily? Y ___ N ___

Reason for today's visit _____

Signature _____ Date _____

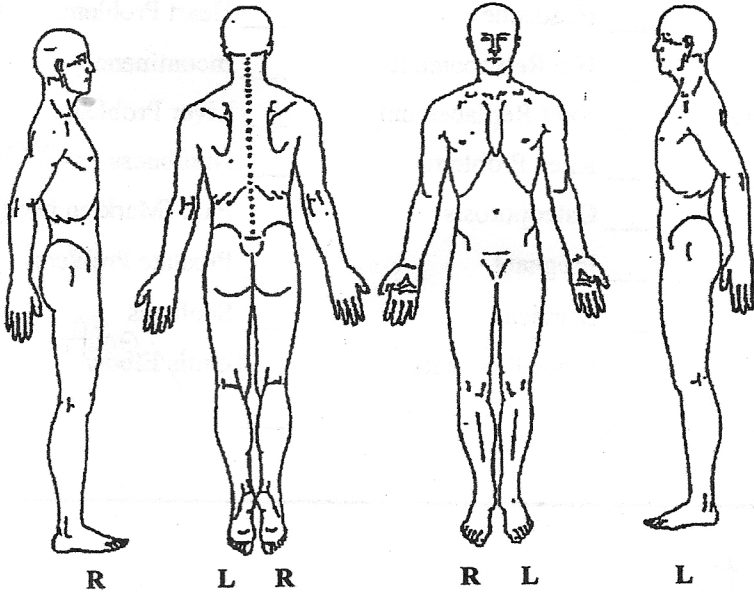
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Continue on back:

Are there things you can't do or stopped doing because of your condition?

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



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):

Notes:

Bowenwork® Intake Form

Name _____ DOB _____
Address _____ CITY _____ ST _____ ZIP _____
Phone: (primary) _____ (alternate) _____
Occupation _____ Sports, hobbies _____
Emergency contact _____
How did you hear about Bowenwork? _____

Please check all that apply:

<input type="checkbox"/> Abdominal / Digestion	<input type="checkbox"/> Fibroids - (location):	<input type="checkbox"/> Joint replacement _____	<input type="checkbox"/> Rib
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Other: _____

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Do you go to the bathroom daily? Y ___ N ___

Reason for today's visit _____

Signature _____ Date _____

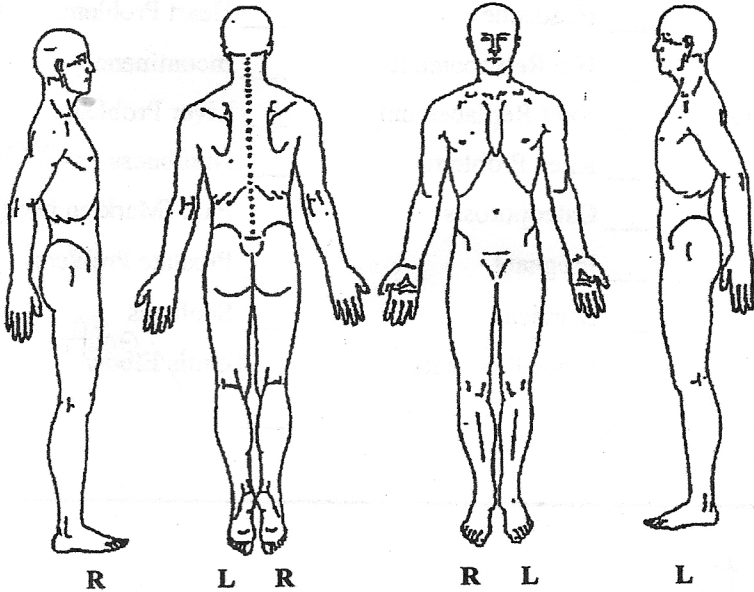
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Other: _____

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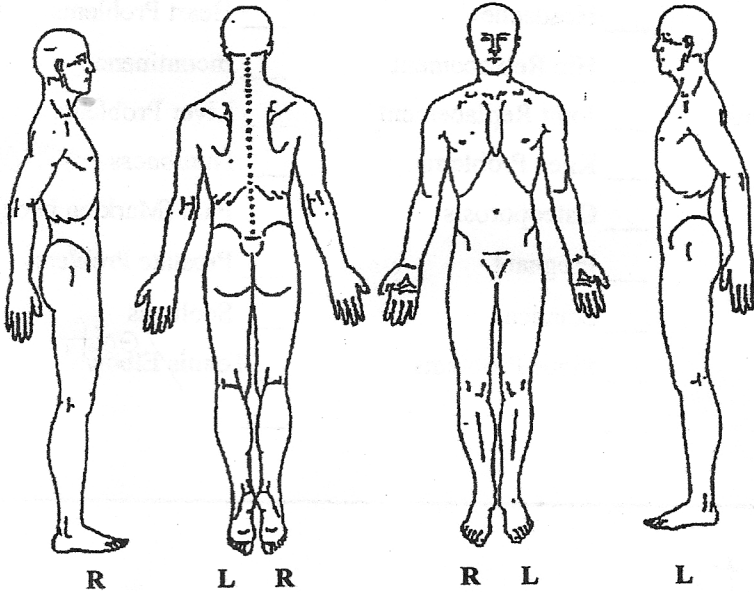
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Phone: (primary) _____ (alternate) _____
Occupation _____ Sports, hobbies _____
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How did you hear about Bowenwork? _____

Please check all that apply:

- | | | | |
|---|--|--|---|
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Other: _____

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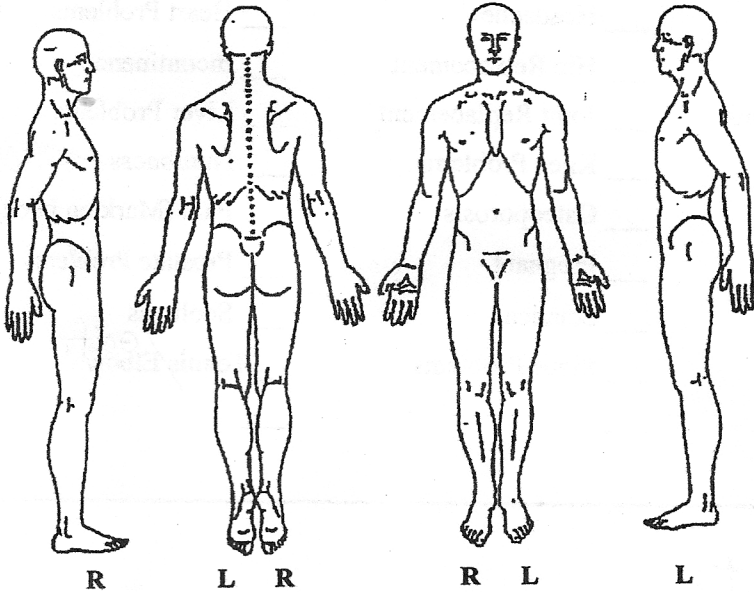
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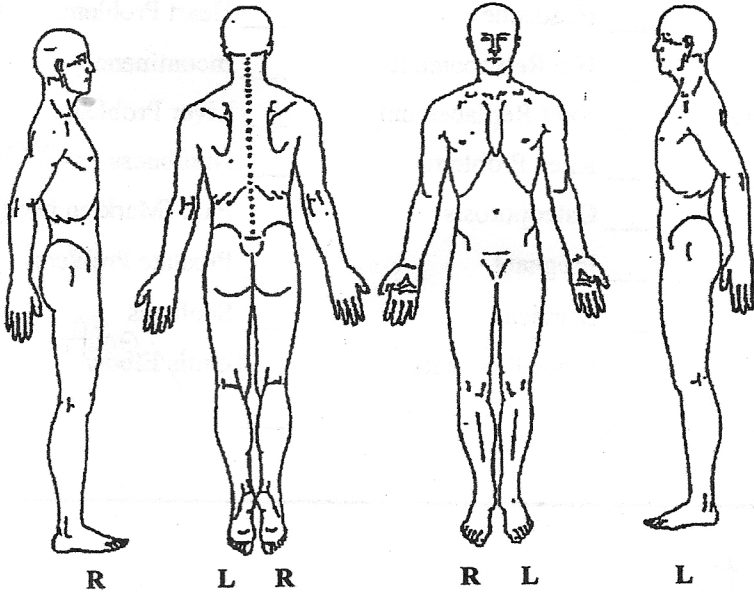
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Other: _____

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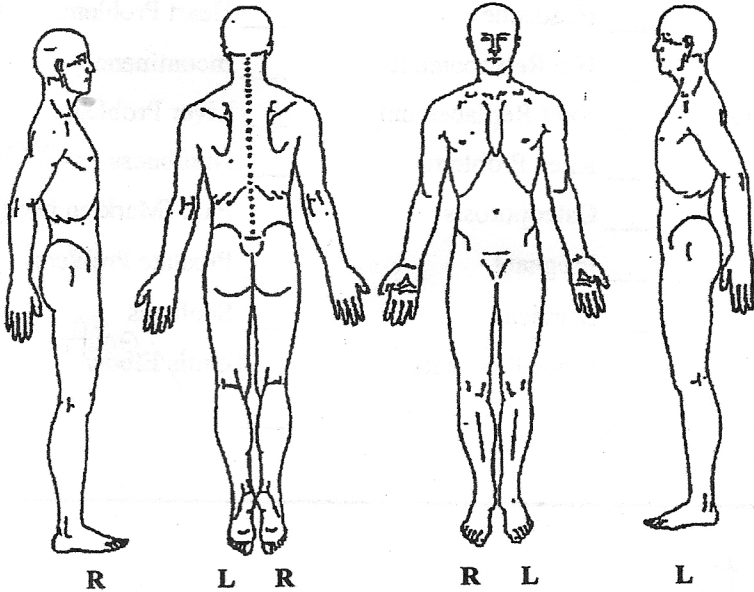
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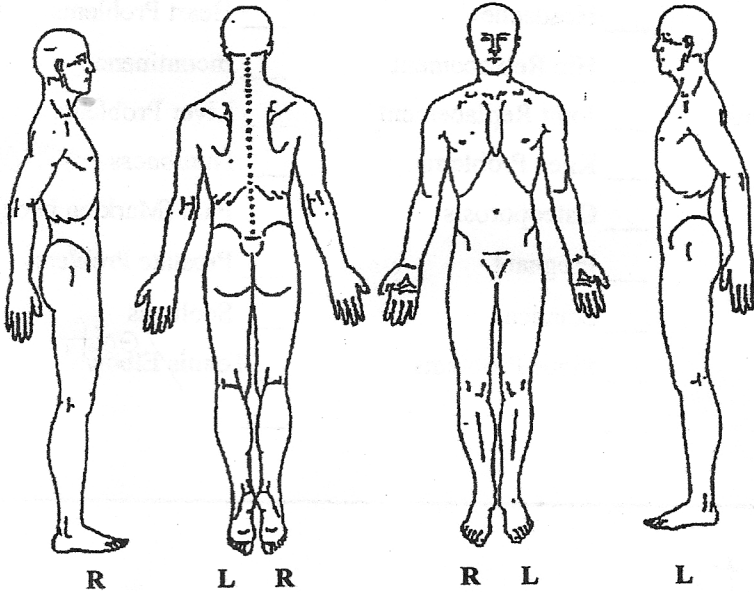
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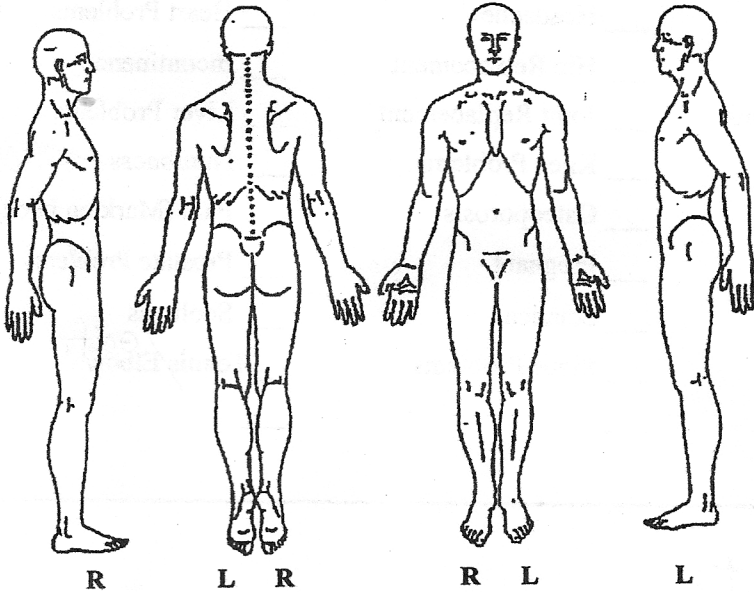
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| <input type="checkbox"/> Breast implants | <input type="checkbox"/> Headaches/ <input type="checkbox"/> Migraines | _____ | <input type="checkbox"/> Uterine or ovary problem |
| <input type="checkbox"/> Cancer / Chemo | <input type="checkbox"/> Heart problem | <input type="checkbox"/> Dental work | <input type="checkbox"/> Back problem |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pelvic pain | CHILDREN / BABIES: |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Incontinence / bladder (adult) | <input type="checkbox"/> PMS/Menopause/Hot Flashes | <input type="checkbox"/> Bed wetting |
| <input type="checkbox"/> Ear problem / <input type="checkbox"/> Eye problem | <input type="checkbox"/> Infertility | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Colic |
| <input type="checkbox"/> Swelling _____ | <input type="checkbox"/> Jaw / TMJ problem | <input type="checkbox"/> Prostate problem | <input type="checkbox"/> Trouble breast feeding |

Other: _____

Do you have any pain or difficulty eating? Y ___ N ___ Do you have any pain or difficulty going to the bathroom? Y ___ N ___

Do you go to the bathroom daily? Y ___ N ___

Reason for today's visit _____

Signature _____ Date _____

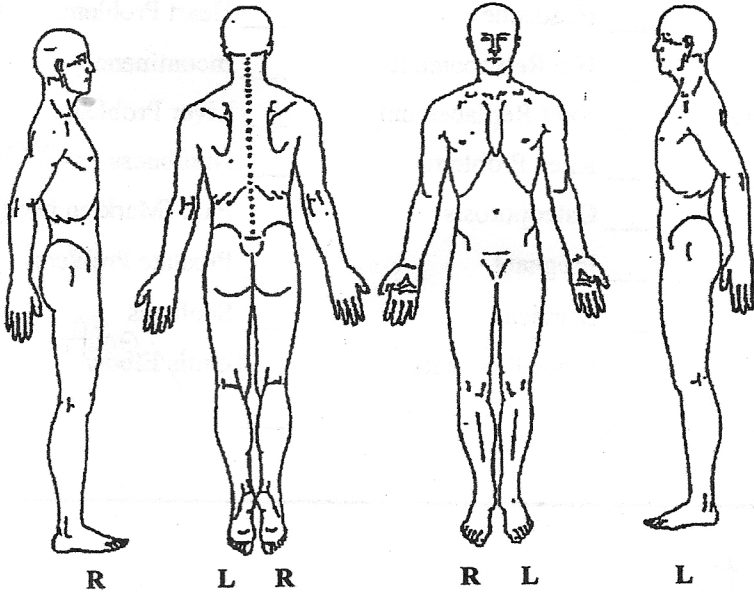
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Continue on back:

Are there things you can't do or stopped doing because of your condition?

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



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):

Notes:

Bowenwork® Intake Form

Name _____ DOB _____
Address _____ CITY _____ ST _____ ZIP _____
Phone: (primary) _____ (alternate) _____
Occupation _____ Sports, hobbies _____
Emergency contact _____
How did you hear about Bowenwork? _____

Please check all that apply:

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Other: _____

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Do you go to the bathroom daily? Y ___ N ___

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Signature _____ Date _____

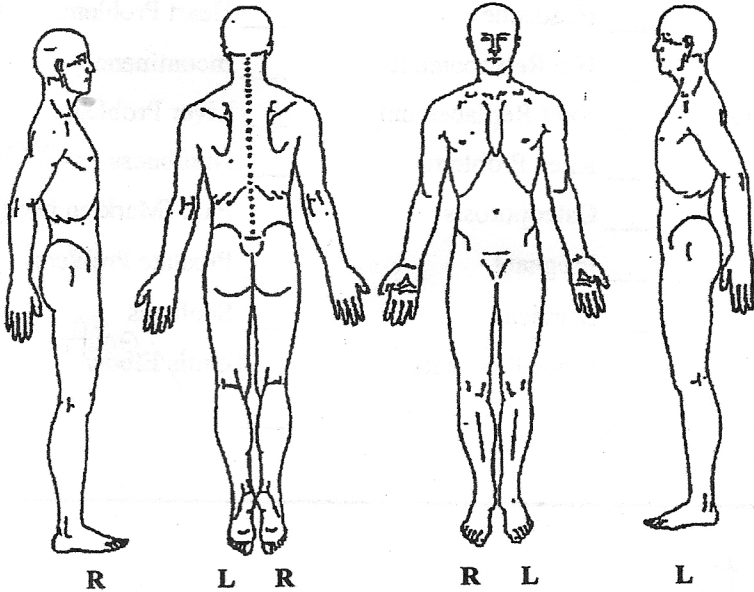
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Pain intensity scale –

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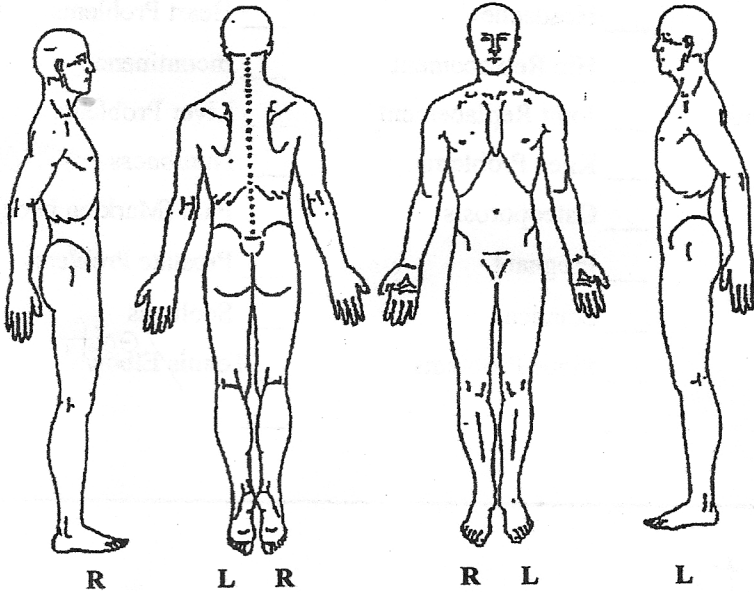
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Other: _____

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Do you go to the bathroom daily? Y ___ N ___

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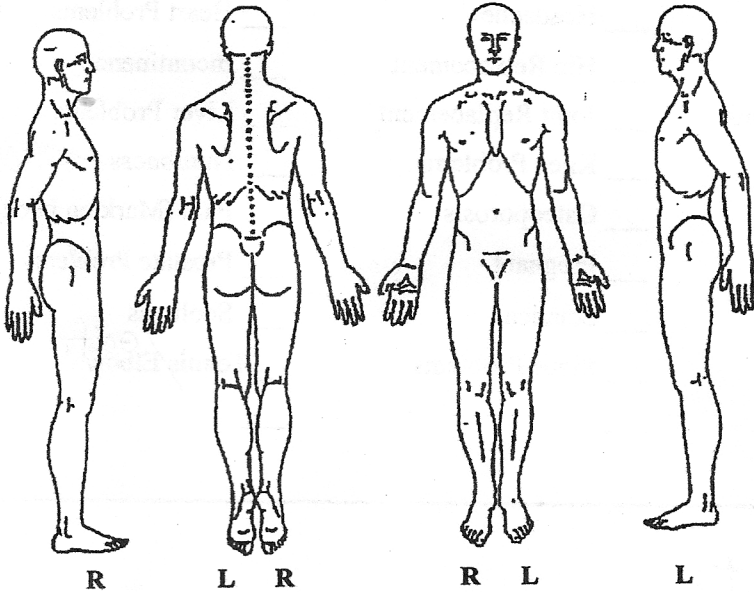
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Other: _____

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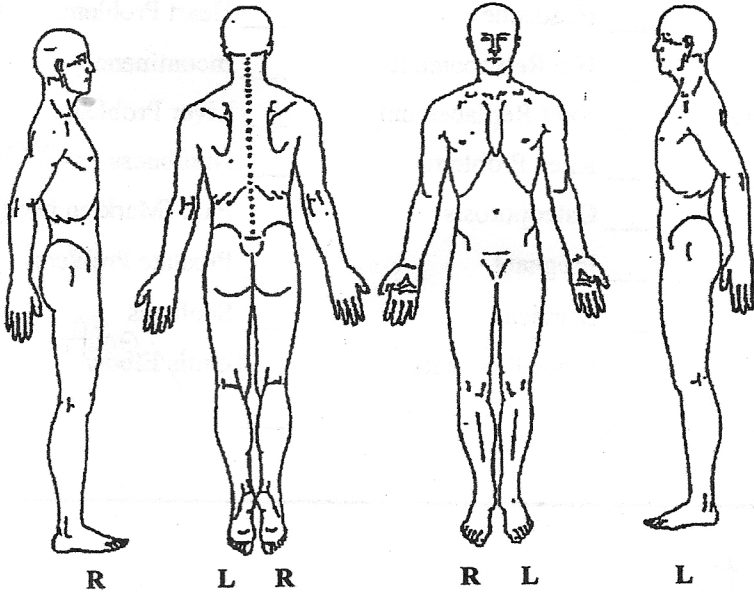
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Do you have any pain or difficulty eating? Y ___ N ___ Do you have any pain or difficulty going to the bathroom? Y ___ N ___

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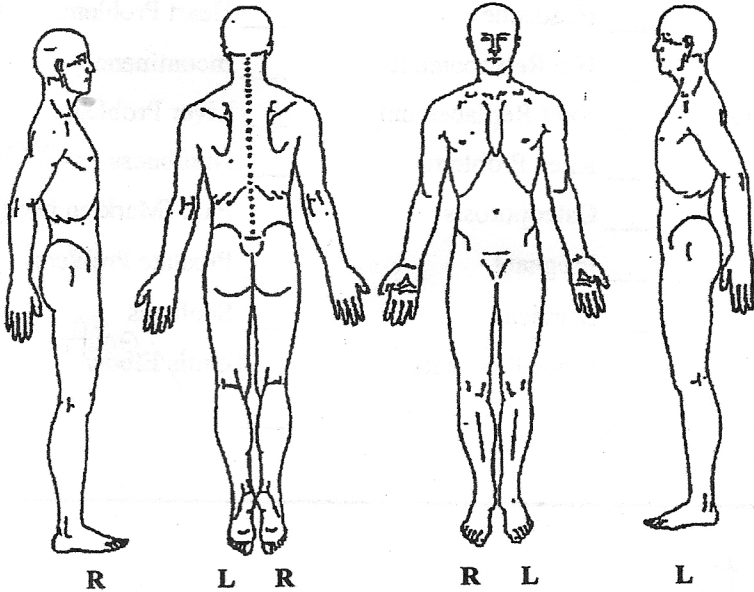
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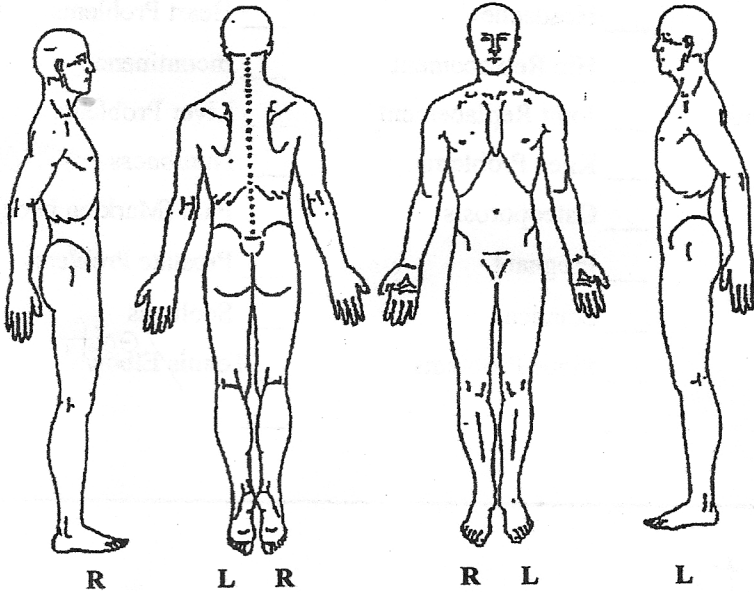
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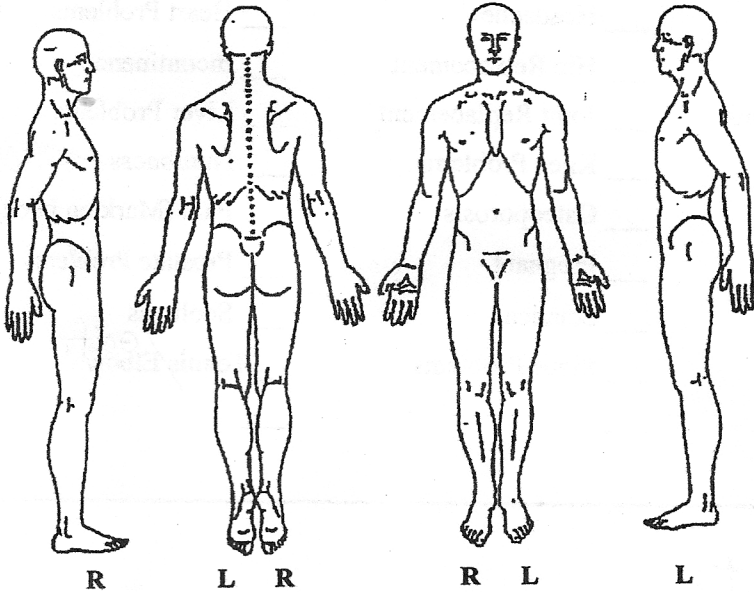
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<input type="checkbox"/> Breast implants	<input type="checkbox"/> Headaches/ <input type="checkbox"/> Migraines	_____	<input type="checkbox"/> Uterine or ovary problem
<input type="checkbox"/> Cancer / Chemo	<input type="checkbox"/> Heart problem	<input type="checkbox"/> Dental work	<input type="checkbox"/> Back problem
<input type="checkbox"/> Concussion	<input type="checkbox"/> Hernia	<input type="checkbox"/> Pelvic pain	CHILDREN / BABIES:
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Incontinence / bladder (adult)	<input type="checkbox"/> PMS/Menopause/Hot Flashes	<input type="checkbox"/> Bed wetting
<input type="checkbox"/> Ear problem / <input type="checkbox"/> Eye problem	<input type="checkbox"/> Infertility	<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Colic
<input type="checkbox"/> Swelling _____	<input type="checkbox"/> Jaw / TMJ problem	<input type="checkbox"/> Prostate problem	<input type="checkbox"/> Trouble breast feeding

Other: _____

Do you have any pain or difficulty eating? Y ___ N ___ Do you have any pain or difficulty going to the bathroom? Y ___ N ___

Do you go to the bathroom daily? Y ___ N ___

Reason for today's visit _____

Signature _____ Date _____

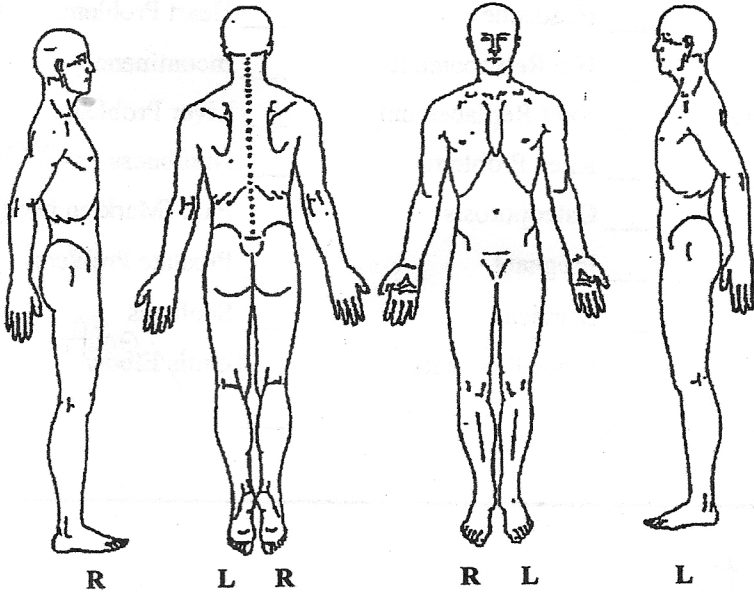
I have stated, to the best of my knowledge, my known medical conditions. I understand that Bowenwork is given for the purpose of stress reduction, relief from muscular tension and/or spasm, facilitation of circulation and energy flow, and relief from stiffness. I understand that the practitioner does 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.

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 back:

Are there things you can't do or stopped doing because of your condition?

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



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):

Notes:

Bowenwork® Intake Form

Name _____ DOB _____
Address _____ CITY _____ ST _____ ZIP _____
Phone: (primary) _____ (alternate) _____
Occupation _____ Sports, hobbies _____
Emergency contact _____
How did you hear about Bowenwork? _____

Please check all that apply:

<input type="checkbox"/> Abdominal / Digestion	<input type="checkbox"/> Fibroids - (location):	<input type="checkbox"/> Joint replacement _____	<input type="checkbox"/> Rib
<input type="checkbox"/> Constipation / <input type="checkbox"/> Diarrhea	<input type="checkbox"/> Fracture (old ___ new ___)	<input type="checkbox"/> Liver problem	<input type="checkbox"/> Sinus problem
<input type="checkbox"/> Asthma	<input type="checkbox"/> Fallen on tailbone	<input type="checkbox"/> Lung problem	<input type="checkbox"/> Shoulder problem
<input type="checkbox"/> Breast lump/ Breast pain	<input type="checkbox"/> Gall bladder problem	<input type="checkbox"/> Numbness --(location):	<input type="checkbox"/> Tinnitus (ringing in ears)
<input type="checkbox"/> Breast implants	<input type="checkbox"/> Headaches/ <input type="checkbox"/> Migraines	_____	<input type="checkbox"/> Uterine or ovary problem
<input type="checkbox"/> Cancer / Chemo	<input type="checkbox"/> Heart problem	<input type="checkbox"/> Dental work	<input type="checkbox"/> Back problem
<input type="checkbox"/> Concussion	<input type="checkbox"/> Hernia	<input type="checkbox"/> Pelvic pain	CHILDREN / BABIES:
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Incontinence / bladder (adult)	<input type="checkbox"/> PMS/Menopause/Hot Flashes	<input type="checkbox"/> Bed wetting
<input type="checkbox"/> Ear problem / <input type="checkbox"/> Eye problem	<input type="checkbox"/> Infertility	<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Colic
<input type="checkbox"/> Swelling _____	<input type="checkbox"/> Jaw / TMJ problem	<input type="checkbox"/> Prostate problem	<input type="checkbox"/> Trouble breast feeding

Other: _____

Do you have any pain or difficulty eating? Y ___ N ___ Do you have any pain or difficulty going to the bathroom? Y ___ N ___

Do you go to the bathroom daily? Y ___ N ___

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Signature _____ Date _____

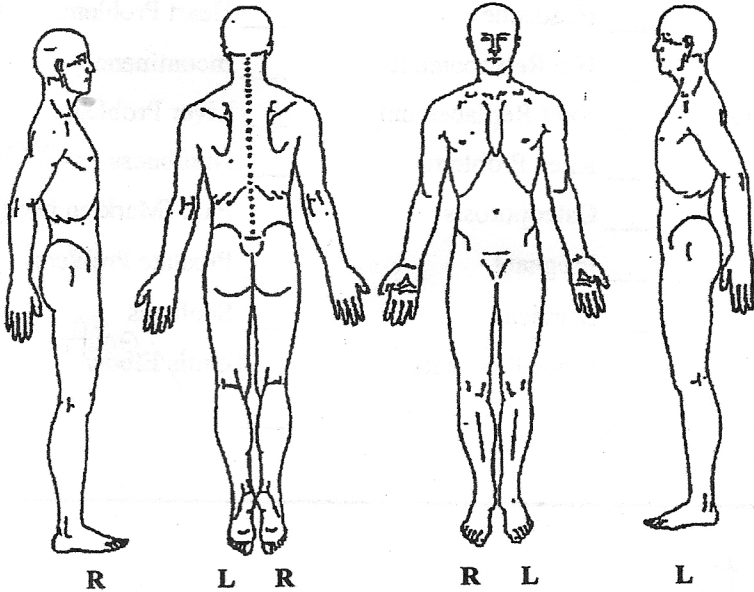
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