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:

__**Abdominal / Digestion**	__Fibroids - (location):	__Joint replacement _____	__Rib
__**Constipation / __Diarrhea**	__Fracture (old__ new__)	__Liver problem	__Sinus problem
__Asthma	__Fallen on tailbone	__Lung problem	__Shoulder problem
__Breast lump/ Breast pain	__Gall bladder problem	__Numbness --(location):	__Tinnitus (ringing in ears)
__Breast implants	__**Headaches/__Migraines**	_____	__Uterine or ovary problem
__Cancer / Chemo	__Heart problem	__Dental work	__Back problem
__**Concussion**	__Hernia	__Pelvic pain	**CHILDREN / BABIES:**
__Dizziness	__Incontinence / bladder (adult)	__PMS/Menopause/Hot Flashes	__Bed wetting
__Ear problem / __Eye problem	__Infertility	__Pregnancy	__Colic
__Swelling_____	__Jaw / TMJ problem	__Prostate problem	__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.

_____

_____

_____

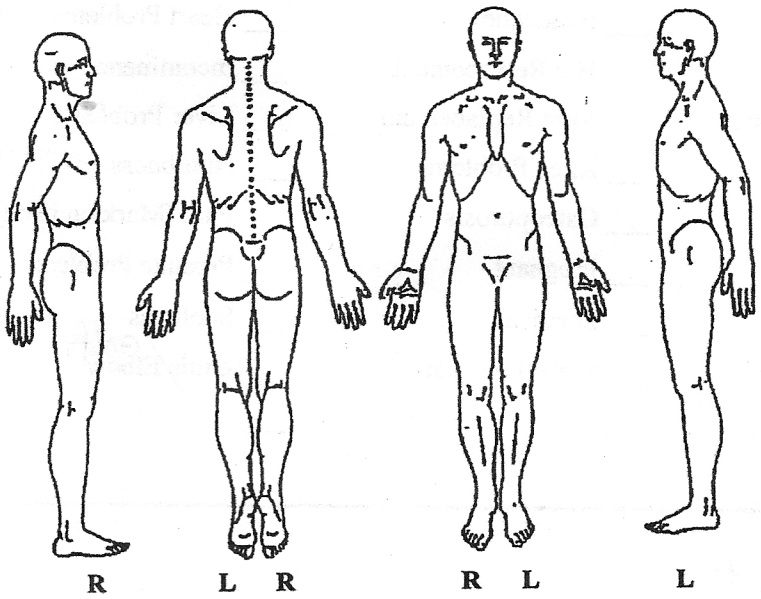
Continue on back:

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:

_____

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