

# Bowenwork® Intake Form

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

Address \_\_\_\_\_

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

Phone: (h) \_\_\_\_\_ (w) \_\_\_\_\_ (c) \_\_\_\_\_

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

Emergency contact \_\_\_\_\_

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

**Please check all that apply:**

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

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.*

**Continue on back:**

**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.**

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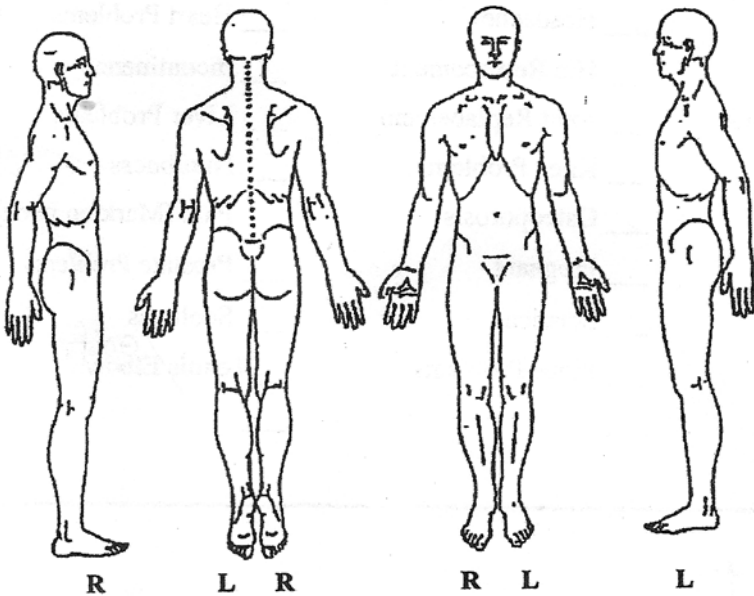
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**List activities compromised by condition(s):**

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



<b>Neck ROM:</b>
L
R
<b>TMJ:</b>
<b>Shoulder ROM:</b>
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):**

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

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