

Date: _____

Name _____ DOB _____ M / F _____

Address _____

Email (Bowenwork use only) _____ Phone _____

Occupation _____ Sports, hobbies _____

Referred by _____

Please check all that apply:

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

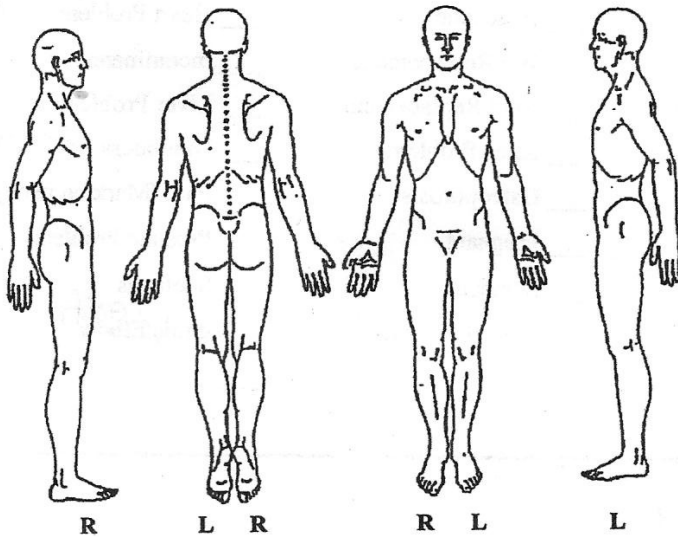
Describe your condition(s), including length of time experienced. Please list all relevant accidents, injuries, surgeries, implants, and falls, including dates of occurrence.

List activities compromised by condition(s):

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

Previous & recent hands-on modalities received:

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)

Session Notes-

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 _____