BOWTECH®
The Original Bowen Technique

NEW CLIENT HEALTH HISTORY / INTAKE FORM

Personal Information:

Name:

_____

Phone (day): _____ Mobile:_____

Address: _____

_____

Email:_____

Date of Birth: _____ Occupation:_____

Emergency Contact Name & Phone: _____

Relation: _____

The following information will be used to help plan your sessions.

Date of Initial Visit: _____

1.Primary Concern for today_____

_____

How long have you had this problem?_____

To what extent does this problem affect your daily life? (work, sleep, eating, etc.)_____

_____

Please list any treatments currently or previously used for this condition and their results:

_____

2. Do you have any difficulty lying on your front, back, or side? Yes No

If yes, please provide more details: _____

_____

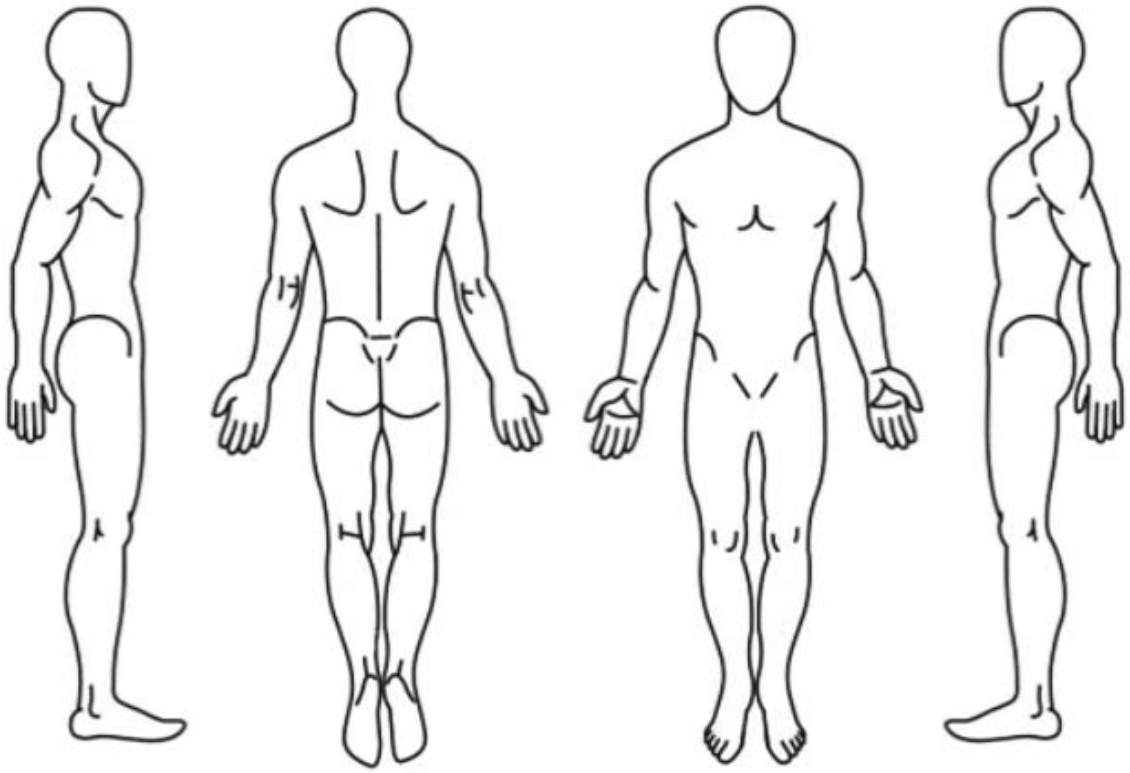
3. Do you sit for long hours at a workstation, computer, or driving? Yes No

If yes, please provide more details:

_____

4. Do you experience stress in your work, family, or other aspect of your life? Yes No

5. Please circle any specific areas of concern , discomfort or pain:



Feel free to provide more details here or indicate the level of pain:

_____

6. Do you experience:

muscle tension ( ) anxiety ( ) insomnia ( ) irritability ( ) other

7.How is your sleep? _____

_____

8. Have you ever damaged your coccyx (tailbone)? Yes No

If yes, how: _____

9. FEMALE ONLY (if applicable) : Are you pregnant? Yes No

If yes, how far along are you? _____

Medical History

In order to plan the session that is safe and effective, we need some general information about your medical history.

1. Are you currently under medical supervision? Yes No

If yes, please explain: _____

2. Do you see a chiropractor? Yes No If yes, how often?

3. Are you currently taking any medication? Yes No
If yes, please list: _____
_____

4. Please check any condition listed below that applies to you:

( ) contagious skin condition
( ) chronic fatigue
( ) groin pain
( ) recent accident or injury
( ) vision problems
( ) chest pain
( ) depression
( ) asthma/respiratory problems
( ) current fever
( ) swollen glands
( ) allergies/sensitivity
( ) heart condition
( ) high or low blood pressure
( ) sinus
( ) teeth grinding
( ) ear problems
( ) headache and migraine

( ) deep vein thrombosis/blood clots
( ) knee/ankle/foot problems
( ) epilepsy
( ) dizziness or tinnitus
( ) cancer
( ) diabetes
( ) hormonal irregularities
( ) back problems/sciatica
( ) Fibromyalgia
( ) TMJ/jaw problems
( ) carpal tunnel syndrome
( ) tennis elbow
( ) neck/shoulder problems

Please provide more details about any condition that you have marked above:

_____
_____
_____

5. Do you wear orthotics
(insoles)_____

6. Have you had any surgery? If so, when?

_____
_____

7. Have you had a surgery on your jaw?_____

8. Do you have any other scars anywhere on your body?

If so, where ? _____

9. Energy levels (0 = low , 10= high)_____

10. Is there anything else about your health history that you think would be useful for your Bowen Therapy practitioner to know ?

_____
_____
_____
_____

Please note: A late cancellation or missed visit leaves a hole in the therapists' day that could have been filled by another patient. We require a reasonable period of notice if you need to reschedule or cancel your appointment, so that we can offer your appointment time to someone else.

Any patient who has missed or cancelled an appointment and not advised us within 24 hours prior to the appointment will be required to provide 50% of full payment for their booked service.

Signature of client: _____ Date: _____

WAIVER AND POLICIES

* I understand the Holistic Health Therapist/ Bowen Therapist doesn't diagnose illness, disease, or any physical or mental disorder. The practitioner does not prescribe medical treatment or pharmaceuticals. It has been made clear that the Bowen Therapy/Indian Head Massage or Scar Tissue Release Technique is not a substitute for medical examination or diagnosis.

* I understand that services offered today, and in the future, are not a substitute for medical care and that any information provided by the therapist are not diagnostically prescriptive in nature.

* I have stated all of medical conditions on the intake form.

* I realize it is solely my responsibility to keep the Therapist updated on any changes in my physical health and I understand that my practitioner shall not be liable should I fail to do so.

* By signing this waiver, I hereby waive and release Yuliana Rokhline, the Bowen Therapist, Holistic Health Therapist and Indian Head Massage Practitioner, from any and all liability, past, present, and future, relating to her services, such as Bowen Therapy, Lifestyle Consultations or Indian Head/Upper Body Massage.

Signature: ________________________________ Date:________________