

Bowenwork[®] Intake Form

Name _____ DOB _____ M / F _____

Address _____

E-mail (Bowenwork use only) _____

Phones (h) _____ (w) _____ (c) _____

Occupation _____ Sports, hobbies _____

Emergency contact _____ Referred by _____

Please mark all that apply to you. Use an H for history of, and a P for present or ongoing issue.

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Abdominal / digestive problem
<input type="checkbox"/> Arthritis – (location):

<input type="checkbox"/> Asthma
<input type="checkbox"/> Ankle problem
<input type="checkbox"/> Anxiety
<input type="checkbox"/> Back pain -- (location):

<input type="checkbox"/> Bed wetting (children)
<input type="checkbox"/> Bone spurs
<input type="checkbox"/> Breast lump
<input type="checkbox"/> Breast pain
<input type="checkbox"/> Breast implants
<input type="checkbox"/> Bronchitis
<input type="checkbox"/> Bunion
<input type="checkbox"/> Bursitis
<input type="checkbox"/> Buttock pain
<input type="checkbox"/> Cancer
<input type="checkbox"/> Carpal tunnel syndrome
<input type="checkbox"/> Chest pain | <input type="checkbox"/> Colic (baby)
<input type="checkbox"/> Constipation
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Diaphragm pain or tightness
<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Dizziness
<input type="checkbox"/> Depression
<input type="checkbox"/> Ear or eye problem
<input type="checkbox"/> Edema, general
<input type="checkbox"/> Elbow pain, tennis or golf
<input type="checkbox"/> Fatigue, chronic
<input type="checkbox"/> Fibromyalgia or polymyalgia
<input type="checkbox"/> Fibroids - (location):

<input type="checkbox"/> Fracture
<input type="checkbox"/> Fallen on tailbone / coccyx
<input type="checkbox"/> Gall bladder problem
<input type="checkbox"/> Heating pad / ice pack usage
<input type="checkbox"/> Heating /cooling salve usage
<input type="checkbox"/> Hammer toes
<input type="checkbox"/> Hamstring pain or tightness
<input type="checkbox"/> Headaches
<input type="checkbox"/> Heart problem | <input type="checkbox"/> Hernia
<input type="checkbox"/> Hip pain
<input type="checkbox"/> Hip replacement
<input type="checkbox"/> Incontinence / bladder (adult)
<input type="checkbox"/> Infertility
<input type="checkbox"/> Jaw / TMJ problem
<input type="checkbox"/> Joint replacement
<input type="checkbox"/> Knee problem
<input type="checkbox"/> Liver problem
<input type="checkbox"/> Lung problem
<input type="checkbox"/> Magnet usage
<input type="checkbox"/> Migraines
<input type="checkbox"/> Numbness --(location):

<input type="checkbox"/> Orthodontia, extensive
<input type="checkbox"/> Orthotics in shoes
<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Pain, other -- (location):

<input type="checkbox"/> Pelvic pain
<input type="checkbox"/> Plantar fasciitis or neuroma
<input type="checkbox"/> PMS or menopause
<input type="checkbox"/> Pregnancy | <input type="checkbox"/> Prostate problem
<input type="checkbox"/> Rib pain / subluxation
<input type="checkbox"/> Sacral pain
<input type="checkbox"/> Sciatica
<input type="checkbox"/> Scoliosis
<input type="checkbox"/> Shin splints
<input type="checkbox"/> Shoulder problem
<input type="checkbox"/> Sinus problem
<input type="checkbox"/> Sleep / energy problem
<input type="checkbox"/> Tinnitus
<input type="checkbox"/> Uterine or ovary problem
<input type="checkbox"/> Wrist or thumb pain

<input type="checkbox"/> Emotional trauma

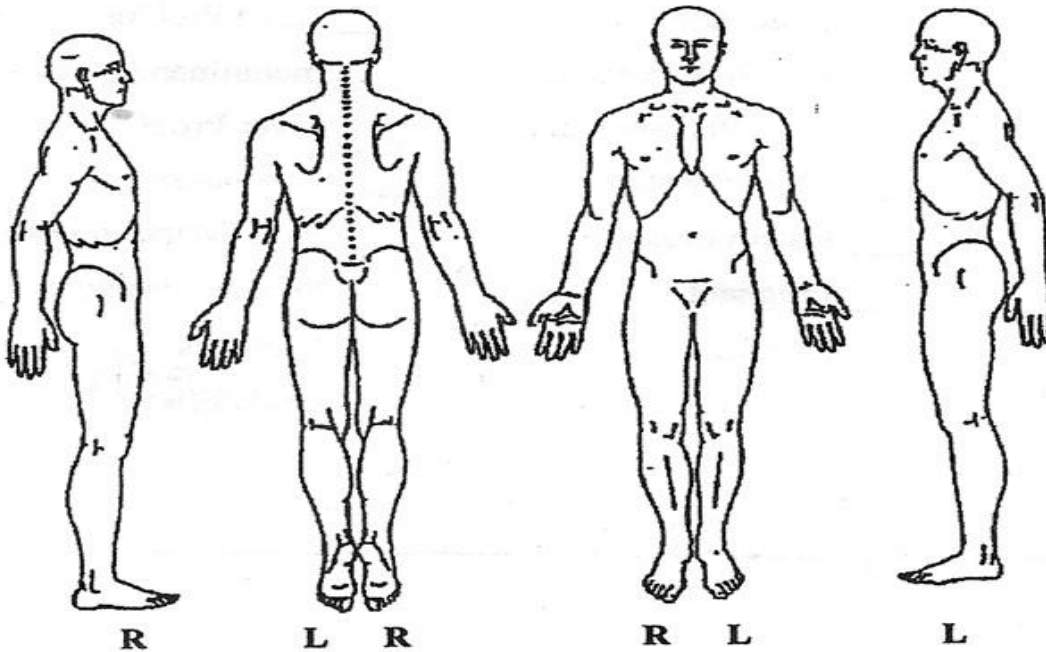
<input type="checkbox"/> Cold weather aggravates symptoms

<input type="checkbox"/> Warm weather aggravates symptoms

<input type="checkbox"/> Skin issues

Other issues wanting to be addressed:
_____ |
|---|---|---|--|

Shade in 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):

Recent hands-on modalities received: _____

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** _____