Client Information

Name: _____ Telephone: ( )_____

Address:

_____

Reason for Visit:

_____

Referred by: _____Telephone: ( )
In Case of Emergency: _____ Telephone: ( )

General & Medical Information:

Occupation: _____ Age: _____ □ male □ female

Sports/Hobbies/Activities:

_____

□ Yes □ No When was your last massage and/or chiropractic treatment ?

□ Yes □ No Do you frequently suffer from stress?
□ Yes □ No Do you have diabetes?
□ Yes □ No Do you experience Migraines?
If yes, How often?
Duration?
Symptoms?
□ Yes □ No Do you have high blood pressure?
□ Yes □ No Are you pregnant?
□ Yes □ No Do you have any problems with your feet?

□ Yes □ No Do you suffer from joint swelling?
□ Yes □ No Do you suffer from epilepsy or seizures?
□ Yes □ No Do you have varicose veins?
□ Yes □ No Do you have elbow/wrist pain?
□ Yes □ No Do you have any digestive problems?
□ Yes □ No Do you grind your teeth?
□ Yes □ No Do you have shoulder problems?
□ Yes □ No Do you have any contagious diseases?

Did you ever injure your tail bone?

□ Yes □ No Do you bruise easily?
□ Yes □ No Do you experience frequent headaches?
□ Yes □ No Have you been in an accident or suffered any injuries in the past two years?
□ Yes □ No Do you have tension or soreness in a specific area?
Please specify:
□ Yes □ No Do you have cardiac or circulatory problems?
□ Yes □ No Do you suffer from back pain?
□ Yes □ No Do you have numbness or stabbing pains anywhere?
Where?
□ Yes □ No Are you very sensitive to touch or pressure in any area?
Where?
□ Yes □ No Have you had surgery in the past 5 years? Explain below.
□ Yes □ No Do you have any other medical conditi0n that I should know about?
□ Yes □ No Do you have ringing in your ears?
□ Yes □ No Do you have any knee pain or swelling?
□ Yes □ No Do you have osteoporosis?

□ Yes □ No Do you have allergies? To what?

Please list any injuries/accidents, and the date of occurrence, you have had:
_____
_____
_____
_____

Please list any surgeries, and the date of occurrence, you have had:
_____
_____
_____

Please list any medications you are currently taking – and the reason:
_____
_____

Please list any X-Ray/Diagnostic report results:_____
_____
_____

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

I understand that Bowen Therapy or Massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that Bowen practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so.

Client Signature: _____ Date: _____

Practitioner Signature: _____ Date: _____

Consent to Treatment of Minor: By my signature below, I hereby authorize _____ to administer Bowen Therapy to my child or dependent, as they deem necessary.

Signature of Parent or Guardian: _____ Date: _____