Bowen Therapy
Confidential Medical History

Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Email Address: _____

Your email address is strictly for the use of BowenWork and will not be shared or sold.

Phone #: _____ (h) _____ (w) _____ (c)

How did you hear about BowenWork? _____

Occupation: _____ How Long? _____

Male / Female Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Emergency Contact Name: _____ Phone #: _____

Family Doctor: _____ Date of last visit: _____

Reason for visit: _____

Comments: _____

Chiropractor: _____ Date of last visit: _____

Reason for visit: _____

Comments: _____

Massage Therapist: _____ Date of last visit: _____

Reason for visit: _____

Comments: _____

Have you been treated with Bowen before? Yes / No Date of last visit: _____

Have you been for any of the following treatments in the past 12 months? ***Please check all that apply.***

☐ Physiotherapy ☐ Reflexology ☐ Acupuncture ☐ Conditioning Therapy

Do you use:

☐ Heating Pads / Ice Pads ☐ Magnets ☐ Heating / Cooling Salves or Creams

Do you do stretches? Yes / No How Often? _____

Do you exercise? Yes / No How Often? _____

What Kind? _____

Are you flexible ? Yes / No Where are you the most **inflexible**? _____

How many hours a night do you sleep? _____ Is your sleep restful? _____

If no, explain: _____

Have you had any **serious falls, accidents or injuries** in the past 5 years? Yes / No

Explain: _____

Date of occurrence: _____

Have you had any **surgeries** in the past 5 years? Yes / No

Explain: _____

Date of occurrence: _____

Have you been in any **motor vehicle accident** in the past 5 years? Yes / No

Explain: _____

Date of occurrence: _____

Headaches: Frequency: _____ Length: _____

Cause: _____

How do you control them: _____

Migraines: Yes / No

Frequency: _____ Length: _____

Please circle all that apply

Water:	cups per day	None	1 - 3	3 - 5	5 - 10	More
Coffee:	cups per day	None	1 - 3	3 - 5	5 - 10	More
Alcohol:	cups per day	None	1 - 3	3 - 5	5 - 10	More
Smoking:	packs per day	None	< 1/2 pack	full pack		More

Current Medications: (*It is sufficient to state purpose such as cholesterol, high blood pressure, osteoporosis, anxiety, pain)*

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

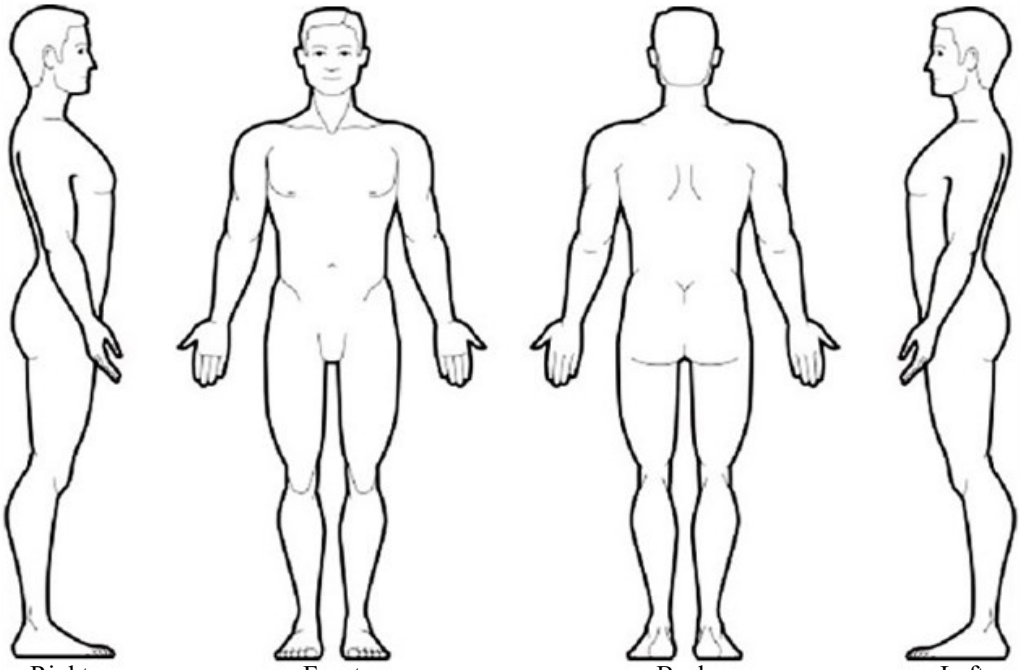
Please check all that apply now and in the past 3 years.

- ☐ Abdominal / Digestive problem
- ☐ Allergies / Hay Fever
- ☐ Arthritis (Osteo / Rheumatoid)
  where: _____
- ☐ Asthma
- ☐ Ankle problems L / R
- ☐ Anxiety
- ☐ Blood Pressure high / low
- ☐ Bone Spurs where: _____
- ☐ Breast Lump L / R
- ☐ Breast Pain L / R
- ☐ Breast / Pectoral Implants
- ☐ Breathing Problems
- ☐ Bronchitis
- ☐ Bunion L / R
- ☐ Bursitis location: _____
- ☐ Buttock Pain L / R
- ☐ Cancer where: _____
  when: _____
- ☐ Carpal Tunnel Syndrome L / R
- ☐ Chest Pain Now / In The Past
- ☐ Constipation
- ☐ Diabetes
- ☐ Diarrhea
- ☐ Dizziness
- ☐ Eye or Ear Problems
- ☐ Edema (swelling) where: _____
- ☐ Elbow Pain tennis / golf
- ☐ Fatigue, chronic
- ☐ Fibromyalgia / Polymyalgia
- ☐ Fracture where: _____
- ☐ Fallen on Tailbone Yes / No Age: _____
- ☐ Gallbladder problem
- ☐ Hamstring Pain / Tightness
- ☐ Heart Problems
- ☐ Hernia where: _____
- ☐ Hip Pain L / R
- ☐ Hip Replacement L / R
- ☐ HIV / Immune Deficiency
- ☐ Incontinence / Bladder (adult)
- ☐ Jaw / TMJ problems
- ☐ Joint Replacement location: _____
- ☐ Knee Pain L / R
- ☐ Knee Replacement L / R
- ☐ Liver problem
- ☐ Lung problem
- ☐ Numbness location: _____
- ☐ Orthodontics (extensive)
- ☐ Osteoporosis
- ☐ Pain (other) location: _____
- ☐ Pelvic pain
- ☐ Plantar Fasciitis / Neuroma
- ☐ PMS / Menopause
- ☐ Pregnancy
- ☐ Prostate problem
- ☐ Rib pain location: _____
- ☐ Sacral pain
- ☐ Sciatica
- ☐ Scoliosis
- ☐ Shin Splints
- ☐ Shoulder problem L /R
- ☐ Sinus problem
- ☐ Sleep / Energy problem
- ☐ Stiff Muscles location: _____
- ☐ Substance / Alcohol Abuse
- ☐ Tinnitus (ringing on the ears)
- ☐ Thyroid problems
- ☐ Uterine / Ovary problems
- ☐ Ulcers
- ☐ Wrist / Thumb pain

Do you have any pain not on this list? Yes / No

Where: _____

Shade in the site(s) of pain on the anatomical drawing and rate the severity of each pain on a scale of 1 - 10.



Right Front Back Left

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)

List in order of importance for you

1. Complaint: _____ Severity on a scale of 1 - 10 *(10 most severe):* _____

Initial Onset: _____ Probable Cause: _____

What makes your pain worse? _____

Activities Compromised by condition: _____

2. Complaint: _____ Severity on a scale of 1 - 10 *(10 most severe):* _____

Initial Onset: _____ Probable Cause: _____

What makes your pain worse? _____

Activities Compromised by condition: _____

3. Complaint: _____ Severity on a scale of 1 - 10 *(10 most severe):* _____

Initial Onset: _____ Probable Cause: _____

What makes your pain worse? _____

Activities Compromised by condition: _____

Comments / Notes of Caution: _____

_____

_____

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: _____