

# Bowenwork® Intake Form

Date: \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_ M / F \_\_\_\_\_

Address \_\_\_\_\_

E-Mail (Bowenwork Use Only) \_\_\_\_\_

Phones (h) \_\_\_\_\_ (w) \_\_\_\_\_ (c) \_\_\_\_\_

Occupation \_\_\_\_\_ Sports, hobbies \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Referred by \_\_\_\_\_

Please check any problems that you have now or have had in the past. Please write F on the line if there is a significant family history (parents, siblings, grandparents, aunts and uncles, children):

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

What are your current health issues? \_\_\_\_\_

How long have you had these conditions? \_\_\_\_\_

What are your other top health concerns? \_\_\_\_\_

What medications are you currently taking? \_\_\_\_\_

1. \_\_\_\_\_ this medication is for: \_\_\_\_\_
2. \_\_\_\_\_ this medication is for: \_\_\_\_\_
3. \_\_\_\_\_ this medication is for: \_\_\_\_\_

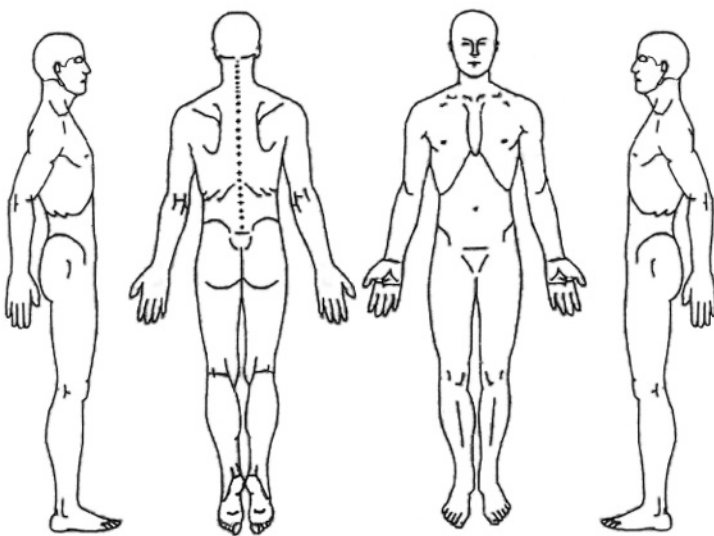
List major illnesses, accidents, injuries, falls and their dates of occurrence:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

List past surgeries and their dates of occurrence: \_\_\_\_\_

List activities compromised by condition(s): \_\_\_\_\_

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



R                    L R                    R L                    L

<b>Neck ROM:</b>
L
R
TMJ
<b>Shoulder ROM:</b>
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)

**Recent medical visits & treatments for:** \_\_\_\_\_

*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.*

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_