Almonte Bowen Therapy Intake Form

Name:_____**Date:**_____

Address:_____**Postal Code:**_____

Phone: _____**Email:**_____

Date of Birth_____**Occupation/Hobbies:**_____

Referred by?_____ **Sign up for newsletter and special offers? YES/NO**

MD's name and phone number_____

Emergency Contact:_____

Please indicate conditions or symptoms you are experiencing or have a history of:

Respiratory
□ chronic cough_____
□ shortness of breath_____
□ bronchitis_____
□ asthma_____
□ tuberculosis (TB)_____
□ Do you smoke?_____

Cardiovascular
□ high/low blood pressure_____
□ heart attack_____
□ heart disease_____
□ stroke_____
□ congestive heart failure_____
□ phlebitis_____
□ pacemaker_____
□ poor circulation_____
□ bruise easily_____

Head / Neck
□ vision problems/loss_____
□ ear/hearing problems_____
□ tinnitus_____
□ headaches/migraines_____
□ concussion _____

Other
□ loss of sensation/numbness_____
□ diabetes_____
□ allergies_____
□ hay fever_____
□ epilepsy_____
□ cancer_____
□ osteoporosis_____
□ constipation/diarrhea_____
□ poor digestion_____
□ liver/gallbladder_____
□ bladder/kidney_____
□ hiatus hernia_____
□ insomnia_____
□ fracture_____
□ fallen on tailbone/coccyx_____
□ orthodontia, extensive_____
□ fibromyalgia_____
□ mononucleosis_____
□ varicose veins_____
□ hepatitis_____
□ HIV _____
□ skin conditions_____
□ bunions/hammer toe _____

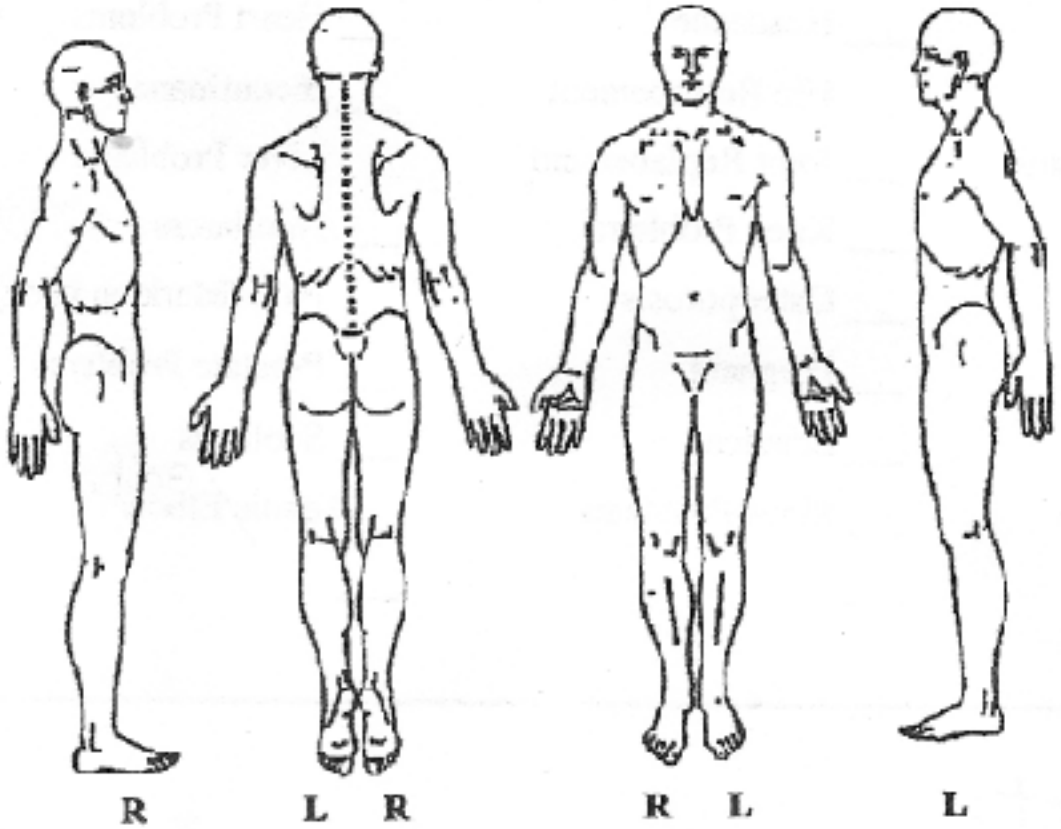
Soft tissue / Joint problems
□ neck_____
□ TMJ / jaw_____
□ low back_____
□ mid back_____
□ upper back_____
□ shoulders_____
□ arms/hands_____
□ hips_____
□ legs/ knees_____
□ feet_____
Do you wear orthotics?_____
□ arthritis (or family history)___
□ pins/wires/artificial joints____
□ other:_____

Women only
□ pregnancy (due_____)
□ trying to conceive_____
□ PMS_____
□ fibroids_____
□ difficult menstruation_____
Last menstrual period
_____

Overall, how is your general health?_____

Primary complaint/reason for treatment_____

Shade in the sites of pain on the drawing and rate the severity of pain on a scale of 1-10. Also draw any scars or known scar tissue:



Pain intensity scale

(2) Mild pain (annoying, nagging)
(4) Discomforting (troublesome, numbing)
(6) Distressing (miserable, gnawing)
(8) Intense (horrible, cramping)
(10) Excruciating (unbearable)

Current medications/supplements (it is sufficient to state purpose, such as cholesterol, high blood pressure, osteoporosis)_____

_____

List injuries with approx. dates_____

_____

List surgeries with approx. dates (include TMJ or oral surgery)_____

_____

Indicate your own birth history if known (ie c section, forceps, breech birth, premature)_____

Have you received any other form of body work in the past five days? Please indicate type.

_____

What is your main treatment goal? What are you hoping the Bowen Therapy will do or allow you to do?

_____

I, (print)_____ understand the treatment goals, risks and benefits as explained by the practitioner and I give consent to treatment. I have had an opportunity to ask questions about the treatment. I understand that Patricia Gervais does not treat, prescribe or diagnose any illness, disease, or other physical or mental disorder and that any information concerning health status relayed to Patricia Gervais has also been given to my physician. I also certify that no guarantee has been made as to the results that may be obtained.

I hereby give Patricia Gervais permission to collect personal information, including personal health information from me and from the facilities and persons listed and to release such information to the following facilities and/or persons for the purpose of providing services to me and for the purpose of information sharing in support of care planning and service provision. These facilities/persons include my health care team i.e. physician, pharmacist, naturopath, RMT, chiropractor or other regulated health care provider. I understand I may request access to my personal information at any time and may revoke or amend this authorization in writing at any time. Upon completion of my treatment program, any request for Patricia Gervais to share/release client-specific information acquired through the episode of care will require a specific informed consent from me for release of specifically requested information.

Signature_____Date _____

Parent or Guardian Signature (if under the age of 18)