CLIENT INTAKE FORM

Wellspring Bowen Therapy
at The Village Clinic

Name_____Phone _____

Address _____

Email_____Date of Birth_____Occupation _____

Emergency Contact _____ Relationship _____ Phone _____

The following information will be used to help plan safe and effective Bowen Therapy sessions. Please answer the questions to the best of your knowledge.

1. Have you had a Bowen therapy session before? Yes No When? _____
2. Do you have any difficulty lying on your front ( ), back ( ), or side ( )?
3. Do you wear contact lenses ( ), dentures ( ), a hearing aid ( ), night guard ( )?
4. Do you sit for long hours at a work station ( ), computer ( ), or driving ( )?
5. Do you perform any repetitive movement in your work, sports, or hobby? Yes No
6. Do you experience stress in your work, family or other aspect of your life? Yes No

   If yes, how do you think it has affected your health?
   muscle tension ( ) anxiety ( ) insomnia ( ) irritability ( ) Other _____

Medical History: In order to plan a Bowen session that is safe and effective, I need some general information about your medical history.

7. Are you currently under medical supervision or taking medication? Yes No

   _____

8. Do you see a chiropractor? Yes No If yes, how often?
9. Please check any condition listed below that applies to you.

( ) Recent accident or injury
( ) Recent surgery
( ) Abdominal problems
( ) Allergies/ Hay Fever
( ) Arthritis
( ) Ankle or foot problems
( ) Back pain
( ) Bed wetting
( ) Bone spurs
( ) Breast lumps or pain
( ) Breast implants
( ) Bursitis
( ) Buttocks pain
( ) Cancer
( ) Carpal Tunnel Syndrome
( ) Chest pain
( ) Constipation
( ) Contagious skin condition
( ) Open sores/ wounds
( ) Diaphragm pain/tightness
( ) Digestive problems
( ) Dizziness
( ) Ear problems/ tinnitus
( ) Edema
( ) Fatigue (chronic)
( ) Fibromyalgia
( ) Fibroids
( ) Fracture (old/ new)
( ) Falls on tailbone/coccyx
( ) Gallbladder problems
( ) Hamstring problems
( ) Headaches/ Migraines
( ) Heart problems
( ) Hernia
( ) Hip problems
( ) Hip replacement
( ) Hormonal problems
( ) Incontinence
( ) Infertility
( ) Jaw/ TMJ problems
( ) Knee problems
( ) Liver/ kidney problems
( ) Lung problems
( ) Menstrual problems
( ) Numbness
( ) Osteoporosis
( ) Pelvic problems
( ) Plantar Fasciitis
( ) Pregnant
( ) Prostate problems
( ) Other _____

Is there anything else about your health history that you think would be useful for your Bowen therapist to know to plan a safe and effective session for you? _____

_____

_____

_____

Mark any specific areas you would like the Bowen therapist to focus on during the session:

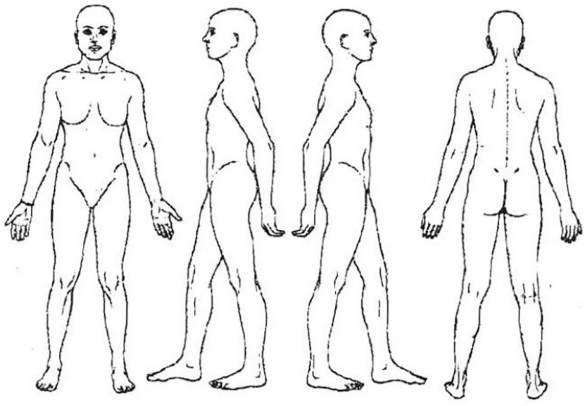
_____

_____

_____

_____

_____



Clients under the age of 18 must be accompanied by a parent or legal guardian during the entire session. Informed written consent must be provided by a parent or a legal guardian for any client under the age of 18.

I,_____(print name) understand that the Bowen Therapy sessionI receive is provided for the basic purpose of relaxation and relief of muscular tension. I further understand that Bowen Therapy 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 coarse of the session given should be construed as such. Because Bowen Therapy should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. 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.

By choosing to have a Bowen session, even with all mentioned safety measures, I acknowledge and accept the additional risks associated with the global health pandemic Covid-19. I release Wellspring Bowen Therapy and The Village Clinic from any and all liability for the unintentional exposure or harm due to Covid-19.

*Signature of Client*_____*Date* _____

Guardian Signature if Applicable _____