leslie lee

Bowen Therapy Consultation
Confidential Client Information

Name:______________________________ Age:______ DOB______________

Address:______________________________

Email:______________________________Tel:______________

Referred by:______________________________

children / ages: ______________________________

Have you experienced Bowen therapy before Yes / No if yes, When? What was the outcome?

Health History

By fully completing this form to the best of your knowledge you help me help you. In order to plan a Bowen session that is safe and effective, All information will be kept confidential.

Do you have any difficulty lying on your front ( ) back ( ) or side ( )

Do you regularly sit for long hours at a workstation ( ) computer ( ) driving ( )

Do you perform any repetitive movements in your work, sports, or hobby? Yes / No

Explain______________________________

Please explain your level of activity ______________________________

Do you experience stress in your work, family or other aspects of your life? Yes / No If yes, how do you think it has affected your health?
muscle tension ( ) anxiety ( ) insomnia ( ) irritability ( ) physically ( ) other ( ) please explain

____

Are you currently under medical supervision or taking medications? Yes / No

please list______________________________

Please list any injuries (acute or chronic) that you have experienced:

____

What other therapies or practitioners are you currently you work with:

Chiropractor Yes / No If yes, how often?______________

Physiotherapist Yes / No If yes, how often?______________

Massage therapist Yes / No If yes, how often? ______________

Other physical therapy Explain / how often? ______________

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Please check any condition listed below that applies to you:

- [ ] Recent accident or injury
- [ ] Recent or planned surgery
- [ ] Abdominal problems
- [ ] Allergies/ Hay Fever
- [ ] Arthritis
- [ ] Ankle or foot problems
- [ ] Back pain
- [ ] Bone spurs
- [ ] Breast implants
- [ ] Bursitis
- [ ] Buttocks pain
- [ ] Cancer
- [ ] Carpal Tunnel Syndrome
- [ ] Chest pain
- [ ] Constipation / Diarrhea
- [ ] skin condition
- [ ] Open sores/ wounds
- [ ] Diaphragm pain/tightness
- [ ] Digestive problems
- [ ] Dizziness
- [ ] Ear problems/ tinnitus
- [ ] Edema
- [ ] Fatigue (chronic)
- [ ] Fibromyalgia
- [ ] Fibroids
- [ ] Fractures (old/ new)
- [ ] Falls on tailbone/coccyx
- [ ] Foot issues
- [ ] Gallbladder problems
- [ ] Hamstring problems
- [ ] Headaches/ Migraines
- [ ] Heart problems
- [ ] Hernia
- [ ] Hip problems
- [ ] Hormonal problems
- [ ] Incontinence
- [ ] Infertility
- [ ] Jaw/ TMJ problems
- [ ] Knee problems
- [ ] Liver/ kidney problems
- [ ] Lung problems
- [ ] Menstrual problems
- [ ] Numbness
- [ ] Osteoporosis
- [ ] Pelvic problems
- [ ] Plantar Fasciitis
- [ ] Pregnant or lactating
- [ ] Prostate issues
- [ ] transgeminal neuralgia
- [ ] Other ___________________
- [ ] Other___________________

Are you experiencing any inflammation? Where?______________________________

What aggravates your pain?______________________________

What helps your pain? ______________________________

What exercise(s) do you do, how much, and how often? ______________________________

What operations have you had? When? Any Complications? ______________________________

____

Is there anything you would like to add? ______________________________

____

Chief complaints / Concerns ? Since? Causes?

____

____

____

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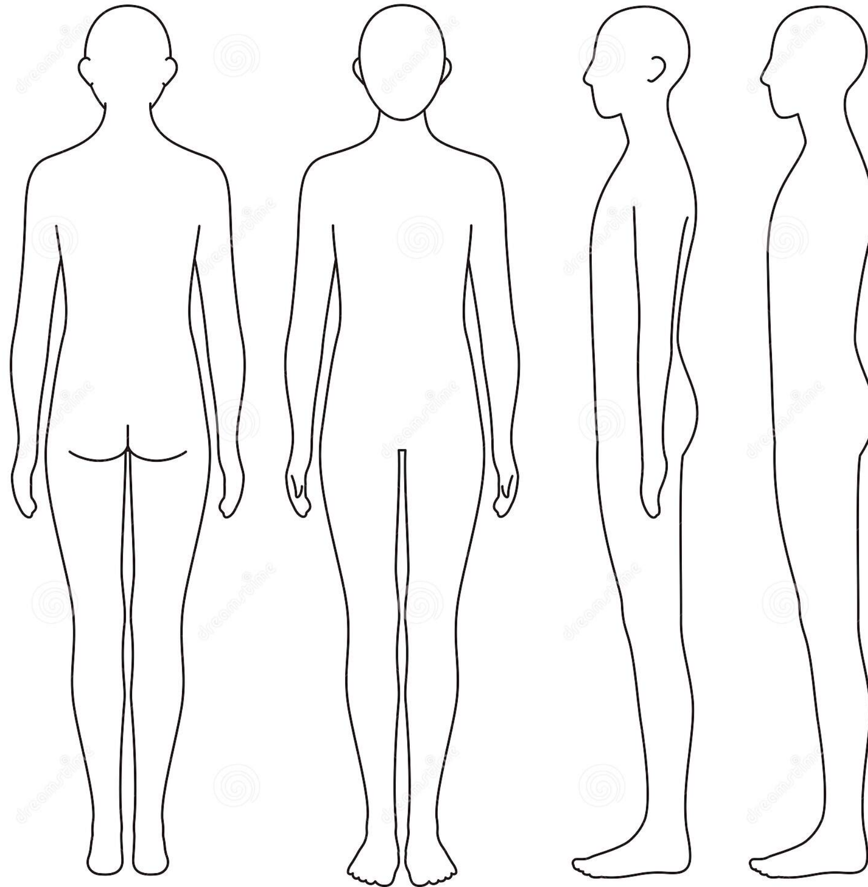

Please use this diagram to indicate where you experience any pain and use the space below to add any notes

How severe is the pain: 1 2 3 4 5 6 7 8 9 10

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CONSENT TO TREAT

I, ______________________________ (print name), 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 course 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. I understand that the Bowen Therapy session I receive is provided for the basic purpose of relaxation and relief of muscular tension. I give full consent for the treatment provided.

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 and with all treatments provided. I release Leslie Lee on behalf of Of Remarkable Beauty Ltd.and The Village Clinic from any and all liability for the unintentional exposure or outcomes.

Signature of Client _________________________________ Date _________________________________

Printed Name :____________________________________

A parent or legal guardian must accompany clients under the age of 18 during the entire session and provide informed written consent.

Guardian Signature ________________________________ Date:_________________________________
(if required)