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 When? What was the outcome?

Medical & 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.

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

2. Do you wear contact lenses ( ), dentures ( ) hearing aid ( ) night guard ( )

3. Do you regularly sit for long hours at a work station ( ) computer ( ) driving ( )

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

explain____

5. 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 ( ) physically( ) please explain

____

6. Are you currently under medical supervision or taking medication? Yes / No please list____

7. 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? yes, how often? ______________________________________

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
- Bone spurs
- Breast implants
- Bursitis
- Buttocks pain
- Cancer
- Carpal Tunnel Syndrome
- Chest pain
- Constipation
- 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
- Prostate problems
- transgeminal neutralgia
- Other _______________

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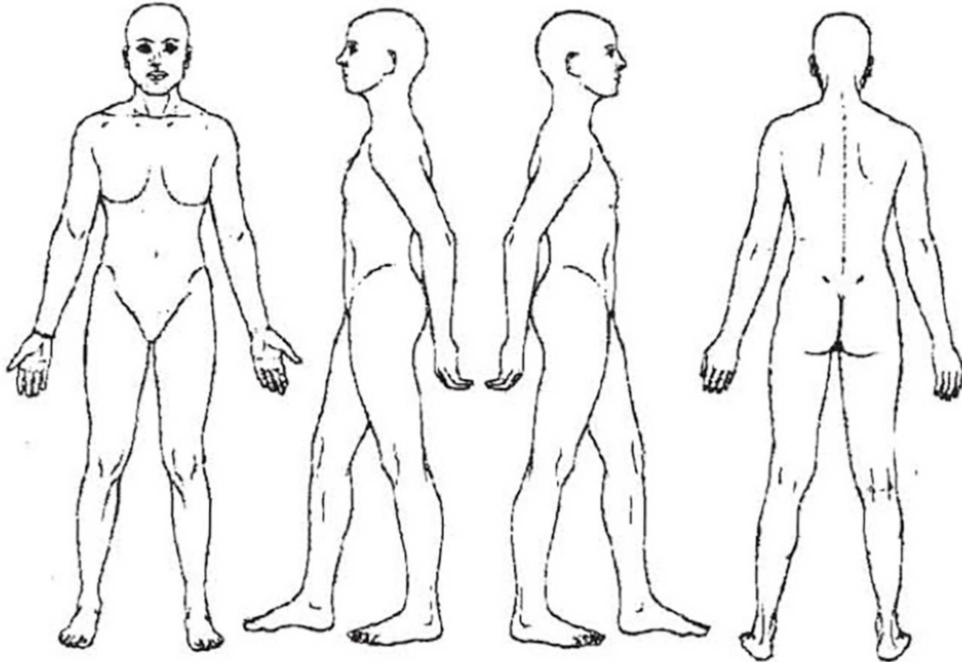
mark this diagram where you experience pain, and on a scale of 1-10 (with 10 indicating severe)



Are you experiencing any swelling? Where?

____

____

What aggravates your pain?

____

____

____

What helps your pain?

____

____

____

Chief complaints? Since? Causes?

____

____

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

____
____
____

What operations have you had? When? Complications?

____
____

Is there anything you would like to add?

____
____