Providence Wholistic Healthcare

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Bowen Client Intake and Health History

Name _____ Date _____

Address _____

City _____ State _____ Zip Code _____

Telephone # (home)_____ (cell)_____

Age _____ Date of Birth _____ Gender: Female Male

Education _____Email:_____

Married ____Partnership ____Separated ____Divorced ____ Widowed ____ Single _____

Live with: Spouse ____ Partner ____ Parents ____ Children ____ Friends ____ Alone ___

Occupation _____ Hours per week _____ Retired _____

Employer _____Work phone contact_____

Work address _____

How did you hear about our clinic? _____

Has any other family member already been a patient at the clinic? _____
Next of Kin or other to reach in an emergency _____
Relationship _____ Phone _____

Address _____

History of Health Condition(s):

When, where & from who did you last receive medical care or general health care?
_____
_____
_____

What was the reason? _____Did you get blood work?_____
What kind of blood work?_____ Please bring a copy for the Doctor.

What is your general state of health (circle one): Excellent Good Average Fair Poor
Are you currently seeing a primary care physician? Who? What are your diagnoses?

_____

Family History: indicate if you or a member of your close family have had the following

	Self	Mother	Father	Brother	Sister(s)	Grandparents (MGP)	(PGP)
Cancer	_____	_____	_____	_____	_____	___/__	___/__
Diabetes	_____	_____	_____	_____	_____	___/__	___/__
Heart Disease	_____	_____	_____	_____	_____	___/__	___/__
High Blood Pressure	_____	_____	_____	_____	_____	___/__	___/__
Stroke	_____	_____	_____	_____	_____	___/__	___/__
Epilepsy	_____	_____	_____	_____	_____	___/__	___/__
Mental Illness	_____	_____	_____	_____	_____	___/__	___/__
Asthma/Allergies	_____	_____	_____	_____	_____	___/__	___/__
Anemia	_____	_____	_____	_____	_____	___/__	___/__
Kidney Disease	_____	_____	_____	_____	_____	___/__	___/__
Bowel Disease	_____	_____	_____	_____	_____	___/__	___/__
Ulcer	_____	_____	_____	_____	_____	___/__	___/__
Tuberculosis	_____	_____	_____	_____	_____	___/__	___/__
Osteoporosis	_____	_____	_____	_____	_____	___/__	___/__
Thyroid disease	_____	_____	_____	_____	_____	___/__	___/__

Your Health History: Any history of negative reactions to vaccination Y N_____

Hospitalizations and Surgeries

_____ year: _____ _____ year: _____

_____ year: _____ _____ year: _____

X-Rays and Special Studies: X-rays, CAT scans, EKGs or other studies you have had:

_____

_____

Allergies: Medications/drugs _____

Environmentals _____

Any Food sensitivities or allergies _____

Current Medications: Do you take or use…

Laxatives	Y N	Pain relievers	Y N	Antacids	Y N
Cortisone	Y N	Appetite suppressants	Y N	Antibiotics	Y N
Tranquilizers	Y N	Thyroid medication	Y N	Sleeping pills	Y N
MAO inhibitors	Y N	Appetite suppressants	Y N	Diuretics	Y N
Stimulants	Y N	ADHD medications	Y N	Steroids	Y N

Please list **all** prescription, OTC meds, vitamins & supplements you are taking & the dose?

1) _____ 6) _____

2) _____ 7) _____

3) _____ 8) _____

4)_____ 9)_____

5)_____ 10_____

Bowen Intake Form

NOTE: All information will be kept confidential.

Name _____ **Date of Birth** _____ **Sex** _____

Address _____ **City** _____ **Zip Code** _____

E-mail _____ **Phone** _____

Please check all that apply

___ Abdominal Problems	___ Allergies	___ Arthritis	___ Asthma
___ Ankle Problems	___ Back Pain	___ Bed Wetting	___ Bone Spurs
___ Breast Lumps	___ Breast Pain	___ Breast Implants	___ Bronchitis
___ Bunions	___ Bursitis	___ Butt Pain	___ Carpal Tunnel Syndrome
___ Chest Pain	___ Colic	___ Constipation	___ Diaphragm Pain
___ Digestive Problems	___ Dizziness	___ Ear Problems	___ Edema
___ Fatigue (Chronic)	___ Fibromyalgia	___ Fracture (Old/ New)	___ Gallbladder Problems
___ Hamstring Problems	___ Hay Fever	___ Headaches	___ Heart Problems
___ Hernia	___ Hip Pain	___ Hip Replacement	___ Incontinence
___ Infertility	___ Jaw & TMJ Problems	___ Joint Replacement	___ Liver Problems
___ Lung Problems	___ Migraines	___ Knee Problems	___ Numbness
___ Orthodontia	___ Osteoporosis	___ Pain (Mark on back)	___ Pelvic Problems
___ Plantar Fascitis	___ Pregnant	___ Prostrate Problems	___ Rib Problems
___ Sacral Problems	___ Sciatica	___ Scoliosis	___ Shin Splints
___ Shoulder Problems	___ Sinus Problems	__ Tennis Elbow	___ Tinnitus

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Please list all Accidents, Injuries, Surgeries and Falls that you can remember.

_____

_____

_____

_____

_____

_____

_____

_____

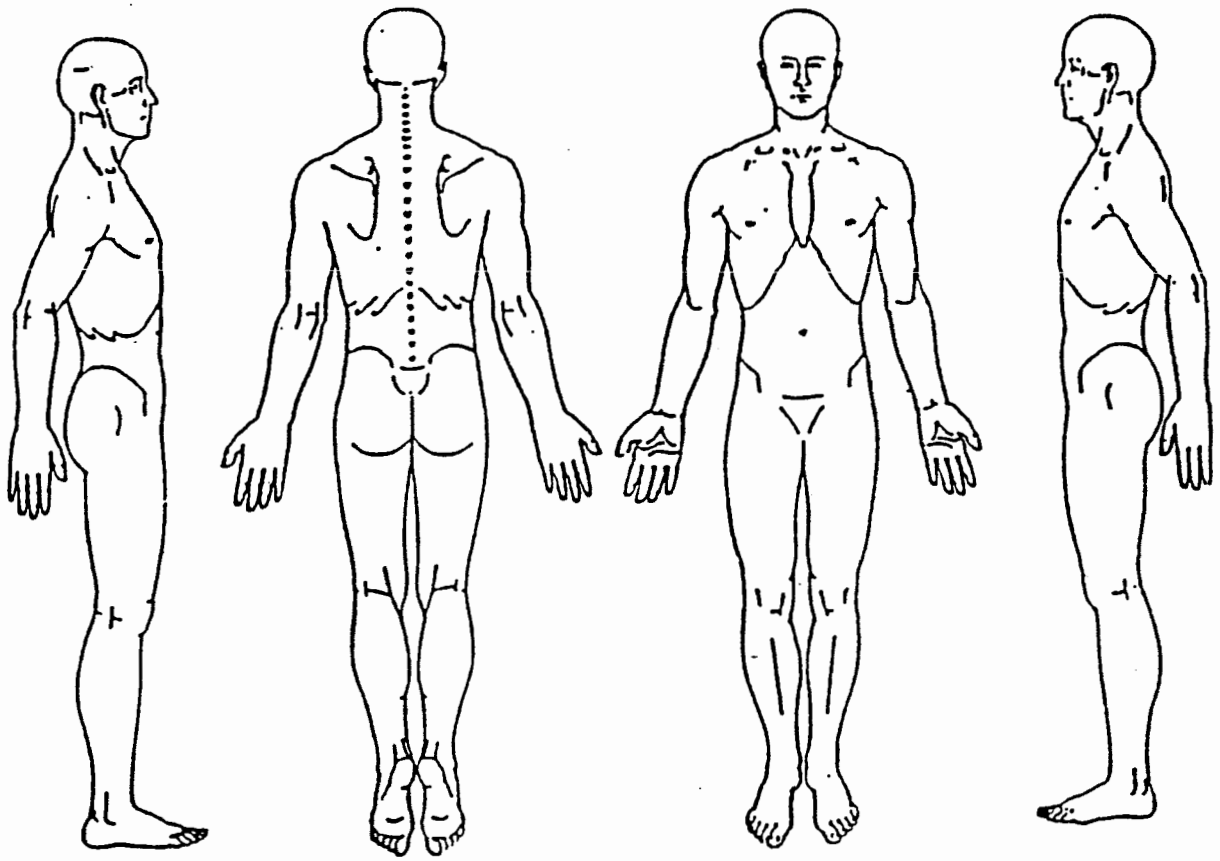
_____

_____

_____

_____

LOCATION OF PAIN: INDICATE WITH X ON ANATOMICAL DRAWING AT THE SITE OF PAIN AND RATE THE SEVERITY OF PAIN – ON A SCALE OF 1 – 10. (CAN BE STATED A RANGE)



Pain Intensity Scale - Pain is described as:

(2) Mild Pain (annoying, nagging)

(4) Discomforting (troublesome, numbing)

(6) Distressing (miserable, agonizing, gnawing)

(8) Intense (cramping, dreadful, horrible)

(10) Excruciating (tearing, crushing, unbearable)

List current medications _____

List current therapies _____

How did you hear about the Bowen Technique _____

Release Statement: I understand that the Bowen Technique is a hands-on therapy and I give my permission for the therapist to touch my body.

_____ _____

Signature **Date**