BowenWork

*** Confidential Medical History ***

Name: _____

Address: _____

City: _____ Prov: _____ PCode: _____

Email Address: _____

Your Email address is strictly for the use of BowenWork and will not be shared or sold.

Phone #: _____ (h) _____ (w) _____(c)

How did you hear about BowenWork?: _____

Employer: _____ Position: _____

Male / Female Date of Birth: ___/___/___ Age: _____ Height: _____ Weight:_____

Month/Day/Year

Single / Married Partner's Name: _____

Children: #: _____ Ages: _____ Partner's Employer: _____

Hobbies / Recreation: _____

_____

Exercise: Heavy / Moderate / Light / None **Water Consumption:** Heavy / Moderate / Light / None

---

Family Doctor: _____ Date of last visit: _____

Reason for visit: _____

Comments: _____

Chiropractor: _____ Date of last visit: _____

Reason for visit: _____

Comments: _____

Massage Therapist: _____ Date of last visit: _____

Reason for visit: _____

Comments: _____

Have you been for any of the following treatments in the last 12 months? *Please check all that apply.*

☐ Physiotherapy ☐ Reflexology ☐ Acupuncture ☐ Conditioning Therapy

How much time do you for yourself to relax?: _____

What do you do to relax? (ie. Hobbies, meditation, etc): _____

Do you exercise? Yes / No

If so, what kind and how often?: _____

How many hours a night do you sleep? _____ Is your sleep restful?: Yes / No

If no, explain: _____

---

1. Have you had any serious falls, accidents or injuries in the past 3 years? Yes / No

   Explain: _____

2. Have you had any surgery in the past 3 years? Yes / No

   Explain: _____

3. Have you been in a motor vehicle accident in the past 10 years? Yes / No

   Dates: _____

Headache: Frequency: _____ Length: _____

Cause: _____ How do you control them: _____

Migraine: Yes / No

Initial Onset: _____ Trigger: _____

Please circle all that apply

Coffee:	cups per day	None	1 - 3	3 - 5	5 - 10	More
Smoking:	packs per day	> 1/2 pkg	1/2 pkg	full pkg	More	
Alcohol:	cups per day	None	1 - 3	3 - 5	5 - 10	More

Current Medications: (it is sufficient to state purpose, such as cholesterol, high blood pressure, osteoporosis)

_____ _____ _____

_____ _____ _____

_____ _____ _____

Health History

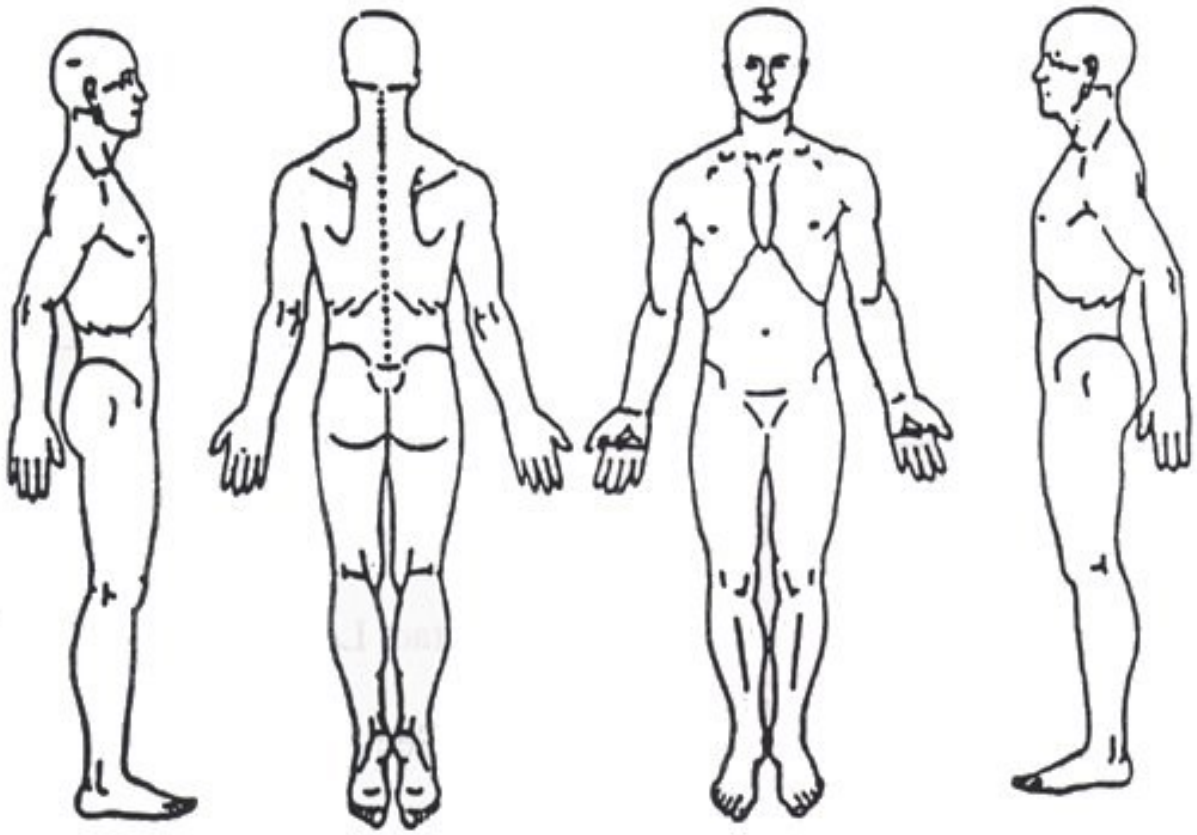
Please check all that apply

__ Abdominal / Digestive problem
__ Allergies / Hay Fever
__ Arthrits _____
Location
__ Asthma
__ Ankle problems L / R
__ Anxiety
__ Back Pain _____
Location
__ Bedwetting (children)
__ Blood Pressure high / low
__ Bone Spurs _____
Location
__ Breast Lump L / R
__ Breast Pain L / R
__ Breast/Pectoral Implants
__ Bronchitis
__ Bunion L / R
__ Bursitis _____
Location
__ Buttock pain L / R
__ Cancer _____
Location
__ Carpal Tunnel Syndrome
__ Chest Pain
__ Colic (baby)
__ Constipation
__ Diabetes
__ Diarrhea
__ Dizziness
__ Eye or Ear problem
__ Edema (swelling) _____
Location
__ Elbow pain: tennis / golf
__ Fatigue, chronic
__ Fibromyalgia or Polymyalgia
__ Fibroids _____
Location
__ Fracture _____
Location
__ Fallen on Tailbone / Coccyx
__ Gall Bladder problem
__ Hammer Toes
__ Hamstring pain or tightness
__ Heart problems
__ Hernia _____
Location
__ Hip pain L / R
__ Hip replacement L / R
__ HIV / Immune Deficiency
__ Incontinence / Bladder (adult)
__ Infertility
__ Jaw / TMJ problem
__ Joint replacement _____
Location
__ Knee problem L / R
__ Liver problem
__ Lung problem
__ Numbness _____
Location
__ Orthodontics (extensive)
__ Orthotics (in shoes)
__ Osteoporosis
__ Pain (Other) _____
Location
__ Pelvic pain
__ Plantar Fasciitis or Neuroma
__ PMS or Menopause
__ Pregnancy
__ Prostate problem
__ Rib pain / Subluxation
__ Sacral pain
__ Sciatica
__ Scoliosis
__ Shin Splints
__ Shoulder problem
__ Sinus problem
__ Sleep / Energy problem
__ Substance / Alcohol abuse
__ Tinnitus (ringing in ears)
__ Thyroid problems
__ Uterine or Ovary problems
__ Ulcers
__ Wrist or Thumb pain

Do you use:

☐ Heating Pads / Ice Packs ☐ Magnets ☐ Heating / Cooling Salves or Creams

Shade in the site(s) of pain on the anatomical drawing, and rate the severity of each pain on a scale of 1 to 10.



Chief Complaint: _____

Initial Onset: _____

Probable Cause: _____

Acute / Chronic

Comments / Notes of Caution: _____

_____

_____

_____

Pain intensity scale

(2) Mild pain
(annoying, nagging)

(4) Discomforting
(troublesome, numbing)

(6) Distressing
(miserable, agonizing, gnawing)

(8) Intense
(cramping, dreadful, horrible)

(10) Excruciating
(tearing, crushing, unbearable)

I have stated, to the best of my knowledge, my known medical conditions. I understand that BowenWork is given for the purpose of stress reduction, relief from muscular tension and/or spasm, facilitation of circulation and energy flow, and relief from stiffness. I understand that the practitioner does not diagnose illness or disease, nor treat specific physical or mental disorders. I will inform my practitioner of any changes in my condition, and will contact my practitioner should I have any concerns.

Signature: _____ Date: _____