insight body therapies

BOWENWORK CLIENT INFORMATION (kept confidential)

Name: Date:

Address, including zip: email address:

Daytime phone: Evening phone:

Emergency contact and phone:

Date of Birth: Age:

Marital Status:

❑ Single ❑ Married ❑ Living with ❑ Widowed ❑ Separated ❑ Divorced

Number of children: Occupation:

Hobbies/Recreation:

By whom were you referred?

List all physical complaints:

Briefly describe the health concern(s) you would like to address in this session. Note when it began, and if there was any trauma at the onset. Rate the severity on a scale of 0 (nonexistent) to 10 (all time worst).

What do you feel caused this problem?

What other approaches have you tried for the problem(s) and how well did they work?

Are you currently in a course of treatment (doctor, chiropractor, acupuncturist, massage,etc.)?

List history of accidents, injuries, surgeries, major illness (with dates):

Are you currently taking cholesterol lowering (statin) drugs?
List medications taken and what they're for:

Please list any chronic condition-- headaches, indigestion, insomnia, allergies, etc.:

Please list your supplements:

What is your daily intake of:
Pure water? _____ 8-oz glasses Fruit juice? _____ Soft drinks? _____
Tea/coffee? _____ cups Alcohol? _____

Briefly describe your diet:

Bowel movements: ____ times/day ____ times/week
Approximate diameter of stool:

How often do you exercise?
❏ daily ❏ weekly ❏ occasionally ❏ never

What types of exercise do you engage in?

On a scale of 1-10 what is your daily vitality?

Do you experience any physical pain you haven't already mentioned? If yes, explain.

Check if you experience:

❑ ringing in the ears ❑ jaw clicking/popping ❑ facial pain

Check if you have:

Orthotic appliances (corrective inlays) in your shoes ____

Breast implants____ Pectoral implants____ Calf implants____

Medical devices implanted_____ Where?

Had any jaw surgery on, or alteration of the temporal-mandibular joint (jaw hinge)____

Have you:

Had hip replacement: R___ L___ Both___ When?

Had knee replacement: R___ L___ Both___ When?

Fallen on your tailbone ____ When?

Had a lymph node removed ___ When and where?

Do you have skin sensitivity to any substances? List:

Do you have food allergies, seasonal or other allergies? List:

Are you pregnant? ❑ yes ❑ no If yes, how many months? _____

Is your menstrual cycle: ❑ regular ❑ irregular ❑ painful ❑ heavy

Are you: ❑ menopausal ❑ other: _____