

# Bowenwork® Intake Form

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ M/F: \_\_\_\_\_

Address (street, city, state, zip): \_\_\_\_\_

Email (Bowenwork use only): \_\_\_\_\_

Phones: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

Occupation: \_\_\_\_\_ Sports, Hobbies: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Emergency Contact Phone: \_\_\_\_\_

Referred By: \_\_\_\_\_

**Please check all that apply:**

- |                                                        |                                                        |                                                         |                                                          |
|--------------------------------------------------------|--------------------------------------------------------|---------------------------------------------------------|----------------------------------------------------------|
| <input type="checkbox"/> Abdominal / digestive problem | <input type="checkbox"/> Chest pain                    | <input type="checkbox"/> Hamstring pain or tightness    | <input type="checkbox"/> Pain, other - (location): _____ |
| <input type="checkbox"/> Allergies / hay fever         | <input type="checkbox"/> Colic (baby)                  | <input type="checkbox"/> Headaches                      | <input type="checkbox"/> Pelvic pain                     |
| <input type="checkbox"/> Arthritis - (location): _____ | <input type="checkbox"/> Constipation                  | <input type="checkbox"/> Heart problem                  | <input type="checkbox"/> Plantar fasciitis or neuroma    |
| <input type="checkbox"/> Asthma                        | <input type="checkbox"/> Diabetes                      | <input type="checkbox"/> Hernia                         | <input type="checkbox"/> PMS or menopause                |
| <input type="checkbox"/> Ankle problem                 | <input type="checkbox"/> Diaphragm pain or tightness   | <input type="checkbox"/> Hip pain                       | <input type="checkbox"/> Pregnancy                       |
| <input type="checkbox"/> Back pain - (location): _____ | <input type="checkbox"/> Diarrhea                      | <input type="checkbox"/> Hip replacement                | <input type="checkbox"/> Prostate problem                |
| <input type="checkbox"/> Bed wetting (children)        | <input type="checkbox"/> Dizziness                     | <input type="checkbox"/> Incontinence / bladder (adult) | <input type="checkbox"/> Rib pain / subluxation          |
| <input type="checkbox"/> Bone spurs                    | <input type="checkbox"/> Ear or eye problem            | <input type="checkbox"/> Infertility                    | <input type="checkbox"/> Sacral pain                     |
| <input type="checkbox"/> Breast lump                   | <input type="checkbox"/> Edema, general                | <input type="checkbox"/> Jaw / TMJ problem              | <input type="checkbox"/> Sciatica                        |
| <input type="checkbox"/> Breast pain                   | <input type="checkbox"/> Elbow pain, tennis or golf    | <input type="checkbox"/> Joint replacement              | <input type="checkbox"/> Scoliosis                       |
| <input type="checkbox"/> Breast implants               | <input type="checkbox"/> Fatigue, chronic              | <input type="checkbox"/> Knee problem                   | <input type="checkbox"/> Shin splints                    |
| <input type="checkbox"/> Bronchitis                    | <input type="checkbox"/> Fibromyalgia or polymyalgia   | <input type="checkbox"/> Liver problem                  | <input type="checkbox"/> Shoulder problem                |
| <input type="checkbox"/> Bunion                        | <input type="checkbox"/> Fibroids - (location): _____  | <input type="checkbox"/> Lung problem                   | <input type="checkbox"/> Sinus problem                   |
| <input type="checkbox"/> Bursitis                      | <input type="checkbox"/> Fracture                      | <input type="checkbox"/> Magnet usage                   | <input type="checkbox"/> Sleep / energy problem          |
| <input type="checkbox"/> Buttock pain                  | <input type="checkbox"/> Gall bladder problem          | <input type="checkbox"/> Migraines                      | <input type="checkbox"/> Tinnitus                        |
| <input type="checkbox"/> Cancer                        | <input type="checkbox"/> Heating pad / ice pack usage  | <input type="checkbox"/> Numbness - (location): _____   | <input type="checkbox"/> Uterine or ovary problem        |
| <input type="checkbox"/> Carpal tunnel syndrome        | <input type="checkbox"/> Heating / cooling salve usage | <input type="checkbox"/> Orthodontia, extensive         | <input type="checkbox"/> Wrist or thumb pain             |
|                                                        | <input type="checkbox"/> Hammer toes                   | <input type="checkbox"/> Orthotics in shoes             | <input type="checkbox"/> Other: _____                    |
|                                                        |                                                        | <input type="checkbox"/> Osteoporosis                   | _____                                                    |

**Describe your condition(s), including length of time experienced. Please list all accidents, injuries, surgeries and falls that might be relevant in any way; include dates of occurrence. Continue on next page:**

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\_\_\_\_\_

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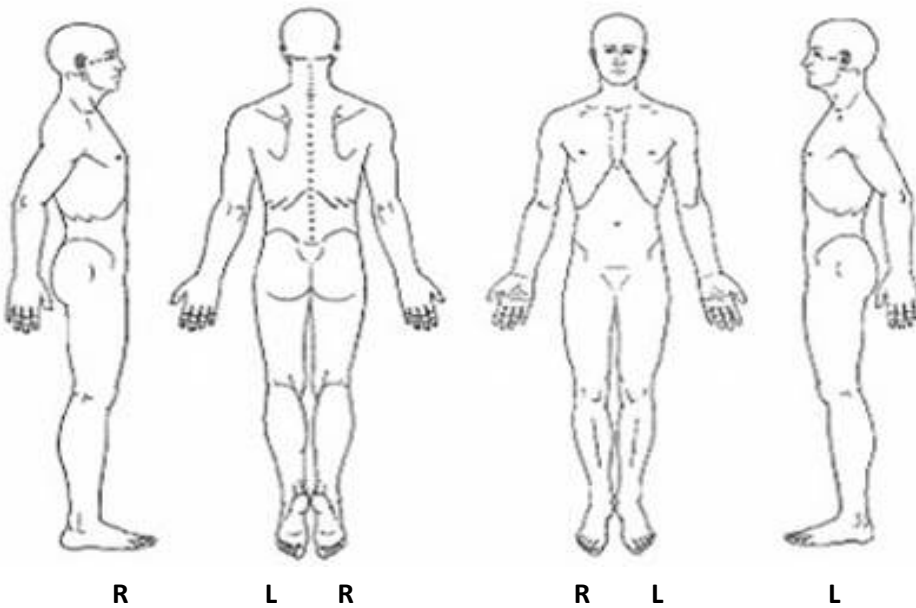
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List activities compromised by condition(s):

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



Neck ROM:
L
R
TMJ:
Shoulder ROM:
L
R

**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)

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

Recent hands-on modalities received: \_\_\_\_\_

*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: \_\_\_\_\_