BOWEN THERAPY FORM

DETAILS

NAME IN FULL: _____

ADDRESS: _____

PHONE: _____EMAIL: _____

OCCUPTAION: _____

DATE OF BIRTH: _____

GENERAL PRACTITIONER/GP/DR: _____

MEDICAL HISTORY

Do you currently or have you ever suffered from the following

High/Low Blood Pressure		**Clicky Jaw**		**Numbness and Tingling**	
Heart/Circulatory problems		**Headaches/Migraines**		**Incontinence**	
Arthritis		**Asthma/Breathing difficulties**		**Depression**	
Cancer		**Sinus**		**Anxiety/Stress**	
Diabetes		**Hernial/Ulcer**		**Chronic Fatigue**	
Osteoporosis		**Fracture**		**Chronic Pain**	
Stroke		**Abdominal or Digestive symptoms**		**Other**	

Allergies_____

Have you ever had a joint reconstruction or replacement?_____

Have you ever had surgery or major dental work?_____

Do you have any implants?_____

Please list any medications you take regularly_____

Do you smoke?_____If so, how many per day?_____

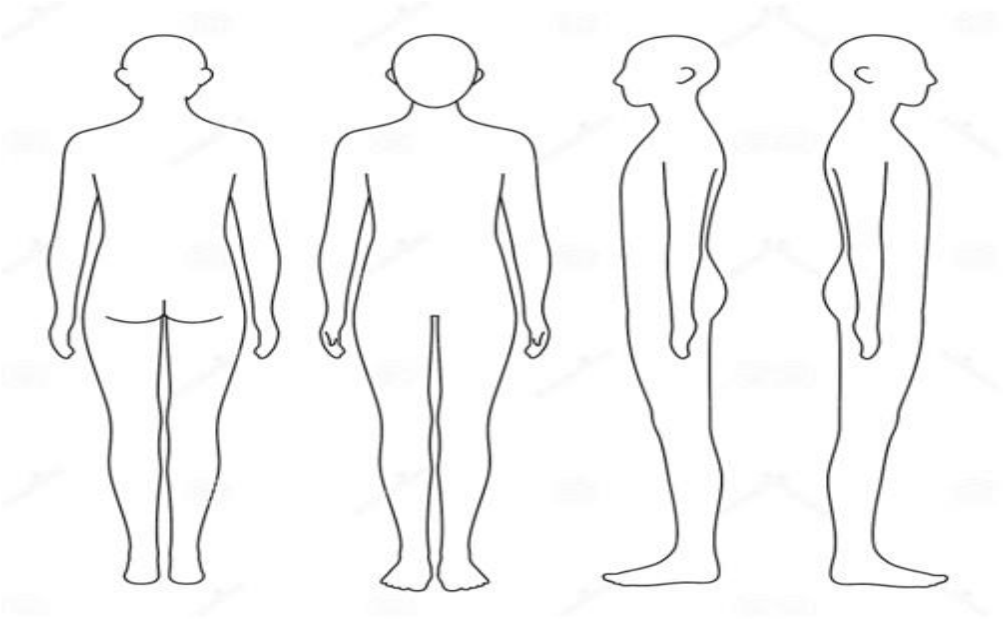
Do you participate in any regular exercise? If so what type?_____

Are you pregnant?_____

What are your Current symptoms?_____

_____

Have you had any previous treatment for this?_____



Indicate any issues or soreness areas on the above diagram.

CONSENT FORM

I understand that Bowen Therapy is a hands on technique which may relieve many symptoms. Bowen Therapy can reduce pain, improve posture and mobility, improve sleep patterns, facilitate relaxation and help the body to rebalance and realign.

Adverse side effects of Bowen Therapy are usually short lived and can include body aches, lethargy, hot, cold or tingling sensations and increased pain. The side effects are temporary and are related to the body's own release of toxins which can occur following treatment, and the body's attempt to rebalance.

I understand that my therapist is not a physician and does not diagnose illness or disease. It is my responsibility to let my therapist know if I am uncomfortable and I to wish to cease treatment.

I acknowledge and understand that my therapist must be fully aware of my existing medical conditions. I have completed my medical history form and disclosed all medical conditions affecting me. It is my responsibility to keep my therapist up to date with my medical history. If I have any concerns it is my responsibility to discuss this with my Bowen Therapist or seek an opinion from my medical practitioner. The information I have provided today is true and complete.

I understand that this information is confidential and will not be shared with any 3rd party unless authorised by myself.

I hereby consent to receive Bowen Therapy treatment.

CLIENT NAME : _____

SIGNED: _____**DATE**: _____