Confidential Bowen Technique Client Consultation Form

Name:.....DOB:.....

Address

Phone Number:
Email: Newsletter request? (max 4 per year)
GP Surgery and contact details:.....
How did you hear about me?
Presenting Complaint (reason for seeking treatment):

Previous medical history (including accidents, operations)

Any medical Diagnosis (date)

Medications:.....

Any digestive problems

Food allergies or other:

Mood (Anxiety/Depression)……
Other therapies tried:……
Recent or current therapist:……
Regular exercise……
Life style / Hobbies……
Energy levels (0 = low -10 high):……
Sleep? well…insomnia……restless……gets up to pee…..children/carer…..wake up tired….other…..
Drink water during day…….how much water…… coffee……tea……alcohol……soft drinks:…...
Occupation and relation to concern……
……
Stress levels: …….high:…….medium…….low……varies……...
Do you have children……..…Carer……
Do you wear orthotic appliances (insoles)……
Have you had any surgery on your jaw?.....Teeth removed?.....
Does your jaw click, or do you ever have facial pain?.....

For Women:

HRT or other endocrine concerns……..…….....

Menses cycle……regular……...irregular……..short cycle……..long cycle…….

Last period……What day now?……Any problems…….....

PMT symptoms……Menopause symptoms.....

Pregnancy – how many weeks…….symptoms……postnatal……

Other:……

How do you hope Bowen might help?

Any other comments/further information that you wish to provide:

The details on this consultation form are an accurate record of my medical history and current condition/s.

I agree to pay the costs for the consultation, treatment/s or course of treatments as detailed below in full on the day. If I have to cancel I will endeavor to give 24 hours notice or pay the full amount.

I agree that all discussion carried out between the therapist and me during my consultation and treatment session will be kept strictly confidential. I will give permission if I wish any details to be passed on to my doctor, health professional or therapist.

I give full consent for my treatment to go ahead.

Our signatures on this agreement indicate full understanding and agreement with the information on this form.

Client ……Date……

Therapist:……Date:……

Parent / Support worker for a child……Date……

Carer/support worker for person unable to sign……Date……