Bowenwork Integrative Health Intake Form

Name: ___________________________ DOB___________ Gender ___________

Address: ______________________________ E-mail (Bowenwork use only): _______________________________

Home #: ________________________ Work #: ________________ Cell #: ___________________

Occupation: ___________________________ Sports/Hobbies: ____

Emergency Contact: ________________________________ Referred by: ______________________________________

Please check all that apply. Use P for past issues and C for current issues.

____Abdominal/Digestive

___ADHD/ADD
___ Allergies/Hay Fever
___Arthritis-location:

____

___Asthma
___Ankle issue
___Anxiety issues
___Back pain-location:

____

___Bed wetting
___Bone Spurs
___Breast Lump
___Breast pain
___Breast Implants
___Bronchitis
___Bunion
___Buttock pain
___Cancer
___Carpel Tunnel
___Chest pain
___Colic (baby)
___Constipation
___Depression issues
___Diabetes
___Diaphragm
___Diarrhea
___Dizziness
___Dyslexia
___Ear or Eye issues

___Edema, general
___Elbow
___Fatigue, chronic

___Fibroids, location:

____

___Fracture, location:

____

___Fallen on Tailbone
___Gall Bladder problems
___Heating or Ice use
___Hammer Toes
___Hamstrings
___Headaches
___Heart problems
___Hernia
___High/Low BP
___Hip pain
___Hip Replacement
___IBS issues
___Implants
___Incontinence/Bladder
___Infertility
___Jaw / TMJ problems*
___Joint Replacement
___Knee problems
___Liver problems
___Lung problem
___Migraines
___Numbness location:

____

___Orthodontia, extensive
___Orthotics in shoes
___Osteoporosis
___ PTSD
___Parkinson's *
___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 issue
___Tinnitus
___Uterine or ovary problem
___ Wrist or Thumb pain

Other:
____
____
____
____
____

***Contraindicated in *some* Bowenwork procedures.**

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Describe your condition (s), including length of time experienced.

Please note any events that you believe may be relevant. (i.e.: motor vehicle accident, fall, etc.)

____

____

____

Surgical history and associated dates:

____

Please list any medications you are currently taking (including over the counter):

____

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____

____

List what you have done to relieve conditions (i.e., Ice packs, heat, stretching, etc. or other types of therapies) List what activities have been compromised by condition(s):

____

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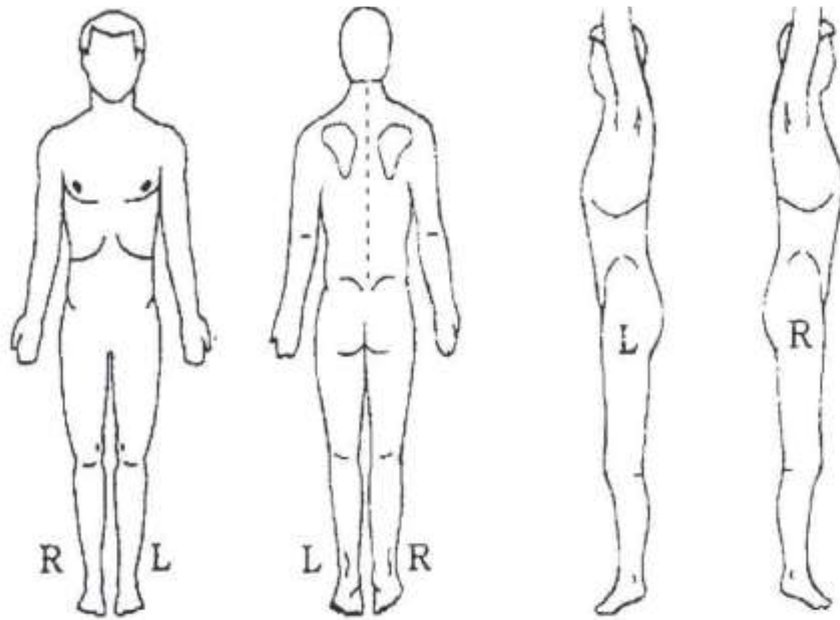
____

____

____



Please indicate area(s) of your current symptoms on the diagram above. Please include any scars you may have.

Additional Notes: ____

____

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Consent for Care

If I experience pain or discomfort during this session and subsequent sessions, I will immediately bring it to the attention of the practitioner.

Further, I understand that Bowenwork® should not be used as a substitute for medical examination, diagnosis, or treatment.

I should see a physician or other qualified medical specialist for any physical or mental conditions of which I am aware.

I understand that the Professional Bowenwork® Practitioners as a standalone credential does not make a practitioner qualified to perform skeletal manipulation, diagnose, prescribe, or treat any physical or mental illness.

Because certain medical conditions contraindicate Bowenwork®, I affirm that I have answered all questions honestly, and stated all known medical conditions.

I agree to keep the practitioners performing Bowenwork® in this office updated to any medical/health changes. I further understand that there shall be no liability on the practitioner's part should I fail to do so.

I understand that close contact with people increases the risk of infection from COVID-19. By signing this form, I acknowledge that I am aware of the risks involved and give consent to receive treatment from this practitioner.

Additionally, I understand that my name and contact information might be shared with the state health department in the event that a client or practitioner at this facility tests positive for COVID-19. My contact details will only be shared in the event they are relevant based on suspected exposure date, and only for appropriate follow-up by the health department.

Understanding all of this, I give my consent to receive care.

Client name (printed): ____________________________________ Date: ____________

Client signature: ____ Date: ___________

Parent/Guardian signature: ________________________________ Date: ____________

Detailed Acknowledgement and Consent to Massage Therapy Treatments

I understand that the massage therapist will assess my tissues, but does not diagnose illness, disease, or any other physical disorder. As such, the massage therapist does not prescribe or perform medical treatment, nor spinal manipulation. It has been made clear to me that massage does not substitute for medical examination or treatment. I understand my responsibility to report changes in my health and to give feedback during treatment so the practitioner and I can work together as a team to optimize my experience. **If I feel uncomfortable for any reason during the session, I am at my liberty to stop the treatment at any time.**

Name ______________________________________ Date ____________

I am happy to work at your comfort level of undressing. We can easily work together through clothing (except shoes and belts).

Please circle how you feel most comfortable receiving massage: while dressed through a sheet on skin

Please initial below to customize your session.

Gluteus, sacrum, and coccyx massage: Treatment to the buttocks and tailbone may be beneficial to reduce back and pelvic pain, and reduce pain radiating down the leg, as well as improve posture and ease walking.

______ I prefer NOT to have this area touched ______ I consent to have this area treated over clothes or a drape _______ I consent to have this area treated undraped (skin contact)

Pelvic and abdominal massage: Treatment to the abdomen, including the lower stomach below the navel and above the pubic bone, as well as the adductor attachments at the groin and pubic bone, may be beneficial to reduce pain, improve respiration, increase flow of blood and lymph fluid throughout the organ tissue as well as relax the fascia and improve posture. **PLEASE NOTE:** The genitals will always remain draped during treatment.

______ I prefer NOT to have this area touched ______ I consent to have this area treated over clothes or a drape _______ I consent to have this area treated undraped (skin contact)

Ribs, diaphragm, and pectoral massage: treatment to the breastbone and underarms, the diaphragm, as well as the upper and lower chest immediately above and below the breast tissue. May be beneficial to reduce pain, improve respiration, increase flow of blood and lymph fluid throughout the organ tissue as well as relax the fascia and improve posture. There may be incidental contact with the breast tissue during this treatment.

______ I prefer NOT to have this area touched ______ I consent to have this area treated over clothes or a drape _______ I consent to have this area treated undraped (skin contact)

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Full chest and breast massage that includes the nipples and areolae: treatment of the breast tissue is performed to increase breast health awareness, relieve congestion and edema in the upper chest and breast, ease tightness due to scar formation from surgery, increase range of motion, prevent stagnation of fluid, alleviate breast symptoms of PMS, enhance milk flow and production for breastfeeding, ease discomforts of pregnancy and breastfeeding, reduce breast and nipple pain, improve respiration, increase flow of blood and lymph fluid throughout the breast tissue, and relax the fascia. If you prefer, you have the option of having a chaperone that you provide in the room during this treatment. You are at your liberty to change your choice during the session or stop at any point during the treatment. **Both men and women have breast tissue, and under current regulations, must consent for massage to be performed on this region.**

______ I prefer NOT to have this area touched

______ I consent to have this area treated over clothes or a drape

_______ I consent to have this area treated undraped (skin contact)

Patient Name ___________________________ **Patient Signature__________________** **Date__________**

Therapist Name _________________________ **Therapist Signature _________________** **Date __________**

Policies

Your signature below signifies that you have read and agree to the policies of Bowenwork Integrative Health.

- Tardiness: Please arrive on time to your appointment. Appointment times are as scheduled and cannot extend past the allotted time due to tardiness. Understand that arriving late to your appointment will shorten your treatment time.
- Cancellation: A 24-hour notice is required for appointment cancellation. Failure to call 24 hours in advance will result in being charged your full session fee.
- Illness: If you are ill, please cancel your appointment as soon as you are aware. The cancellation fee will be waived to accommodate for illness.
- Records: all client information is kept strictly confidential. Release of client records to a third party requires written consent from the respective client, unless subpoenaed by a court of law.
- If you learn you have had a known exposure by close contact to COVID-19 please call and cancel your appointment immediately and notify your primary care provider to guide you in taking proper action.
- *Financial Responsibility: You assume financial responsibility for all services rendered; your signature below signifies acceptance of this policy.*

Signature: ___________________________________ Date: __________

May I have permission to contact your primary care provider and inform them that you are receiving Bowenwork? Yes / No

If yes, please list provider name and number:
____

____

How may I contact you with information regarding your care, after care follow-up and scheduling:

- By: Phone / Text / Email (please circle preferences)
- If by phone, may I leave a detailed voicemail at this number? Yes / No

Signature: _________________________________ Date: __________