THE BOWEN BODY WHISPERER LLC

Intake Form

Name ____ DOB_______________ M / F ________

Address _______________________________________City_____________________zip______________

E-mail (office use only)____

Phones (h)___________________________________(c)__________________________

Occupation_________________________________ Are you a veteran? Y___ N___

Physical Activities and Hobbies ____

Referred by______________________________

Emergency contact _________________________________phone number___________________________

Please check all that apply:

__Abdominal / digestive problem
__Allergies / hay fever
__Arthritis – (location):
____
__Asthma
__Ankle problem
__Back pain -- (location):
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__Bed wetting (children)
__Bone spurs
__Breast lump
__Breast pain
__Bronchitis
__Bunion
__Bursitis
__Buttock pain
__Cancer
Type & date of diagnosis
____

__Carpal tunnel syndrome
__Chest pain
__Colic (baby)
__Constipation
__Diabetes
__Diaphragm pain or tightness
__Diarrhea
__Dizziness
__Ear or eye problem
__Edema, general
__Elbow pain, tennis or golf
__Fatigue, chronic
__Fibromyalgia or polymyalgia
__Fibroids - (location):
____
__Fracture
__Fallen on tailbone / coccyx
__Gall bladder problem
__Heating pad / ice pack usage

__Hammer toes
__Hamstring pain or tightness
__Headaches
__Heart problem
__Hernia
__Hip pain
__Hip replacement
__Incontinence / bladder (adult)
__Infertility
__Jaw / TMJ problem
__Joint replacement
__Knee problem
__Liver problem
__Lung problem
__Lupus
__Migraines
__Numbness --(location):
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__Orthodontia, extensive
__Orthotics in shoes

__Osteoporosis
__Pain, other -- (location):
____
__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 problem
__Tinnitus
__Uterine or ovary problem
__Wrist or thumb pain
__ Other:

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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List activities compromised by condition(s):

____

____

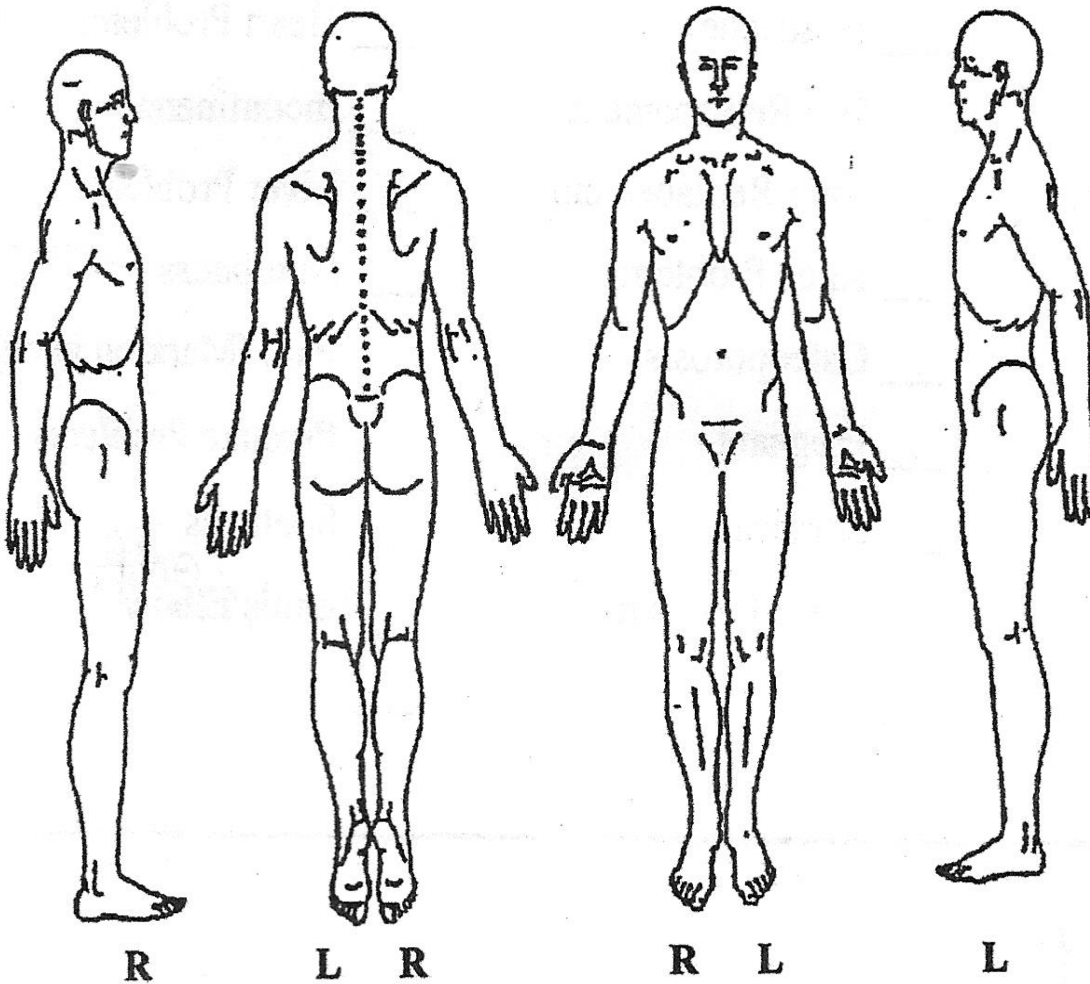
Current medications (it is sufficient to state purpose, such as cholesterol, high blood pressure, osteoporosis):

____

____

Recent hands-on modalities received: ____

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)



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

I have stated, to the best of my knowledge, my known medical conditions. I understand that Bowenwork and massage 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. Payment is due at time of service unless being billed to insurance. If insurance denies payment, I am responsible for payment in full.

Signature____ Date__________________

THE BOWEN BODY WHISPERER LLC
PRIVACY POLICY

ALL INFORMATION IS CONFIDENTIAL. WE MUST HAVE WRITTEN PERMISSION FROM THE CLIENT BEFORE ANY INFORMATION CAN BE COPIED OR SHARED WITH ANYONE.

TREATMENT & PAYMENT POLICY

We reserve the right to terminate the session at any time because of, but not limited to: inappropriate behavior, sexual comments or advances, intoxication, infectious conditions (i.e. flu, poison ivy, lice, etc.), or if the client or therapist's health is in danger. We ask that you communicate with the therapist at all times regarding pressure, pain, comfort, etc. The client and therapist both have the right to terminate a session at anytime if they feel it is necessary. If the therapist terminates the session before the scheduled time, the client may be responsible for the full fee. Payment is due at time of service, unless the treatment is being billed to insurance.
There will be a 25.00 charge for any returned checks.

CANCELLATION POLICY

A cancellation is a lost to both the client and practitioner, however we understand that unanticipated events happen that may require us to cancel our appointments and we want to work with you in any way possible. To make it fair to all our clients and therapist, we have adopted the following policies.
A 24 hour advance notice is required when canceling an appointment. This allows the opportunity for someone else to fill your time slot. If you are unable to notify us 24 hours in advance, you will be charged the full amount of what would have been your treatment fee.
If you are past 15 minutes late for your appointment (unless having telephoned us you might be late) it will be considered a "missed appointment" and that time slot will automatically become available for someone else. Depending upon how late you arrive, your therapist will then determine if there is enough time remaining to start a treatment and regardless of the length of the treatment actually given, **you will be responsible for the "full" session.** Any missed appointments will be charged the full fee and future services will be denied until payment is made.

I have read and understand the policies above.

Client Signature____Date_____________

Signature of Parent
If Client is a Minor___________________________________Date______________