Bowen Intake Form for Minors

Name _____ D/O/B _____

Address _____ Phone _____

City/State _____

Birth history _____

_____

Sports/Hobbies _____

_____

Reason for Bowen _____

_____

_____

Please list any important medical diagnoses or concerns and if your child has received treatment either conventionally or alternatively:

_____

_____

_____

Referred by _____

I, _____, give permission to Holly Halloran of South Shore Bowen Therapy, to provide Bowen Therapy, Assisted Stretching, or Reflexology to my child. I understand they will be appropriately covered/clothed at all times and I will stay at the session at all times. If I opt to wait in the outer sitting area, the treatment room door will remain open.

I understand that Bowen Therapy and related services are complementary and not a substitute for medical care. No diagnosis or guarantee of outcome is made.

Signed with date: _____