BowenWorks Magic - Phoenix
Intake Form
(Your History and Current Issues)

Name _____Male ____ Female _____

Date of Birth (age)_____ Occupation_____

Address _____

City, State, Zip_____

E-mail (BowenWorks Magic use only) _____

Phones (c) _____ (w) _____ (h) _____

Sports, hobbies (limitations or concerns) _____

Emergency contact _____

Referred by which wonderful client or business _____/_____

Describe your condition(s), including length of time experienced. Please list **ALL** accidents, falls, injuries, scars, and surgeries that you can remember**, this is very relevant, very important** in our selections of Bowen procedures to be used. Please include approximate month and year of occurrences if you can. Please include any childhood incidents also. Please add a page(s) as needed:

_____

_____

_____

_____

_____

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_____

_____

_____

_____

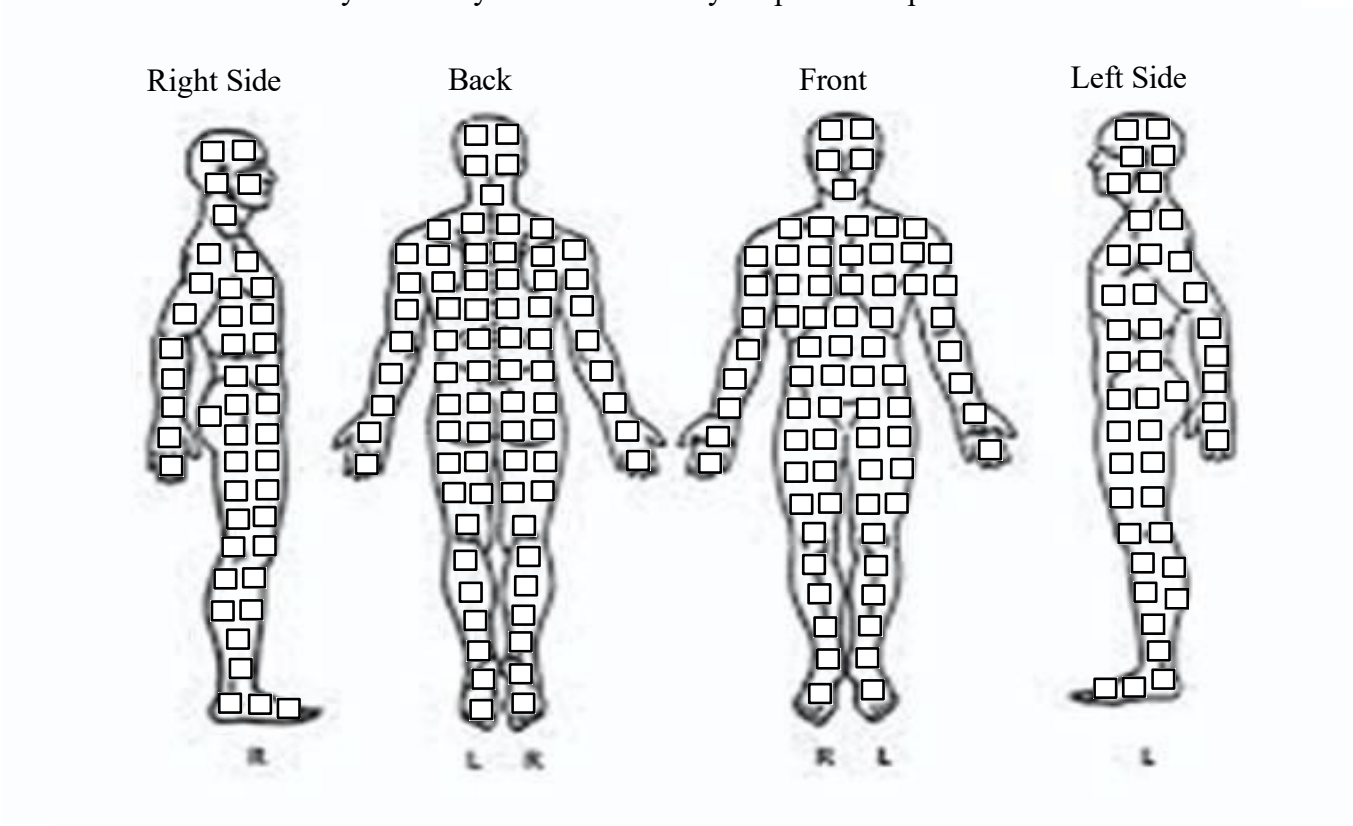
Smoker History? _____how long?_____ Drinker or history of _____

Covid-vaccinated? _____Most recently?_____ Consent signed?_____

Please check all that apply:

- ☐ Abdominal / digestive problem
- ☐ Allergies / hay fever
- ☐ Arthritis – (location):
- ☐ Asthma
- ☐ Ankle problem
- ☐ Back pain -- (location):
- ☐ Bed wetting (children)
- ☐ Bone spurs
- ☐ Breast lump
- ☐ Breast pain
- ☐ Breast implants
- ☐ Bronchitis
- ☐ Bunion
- ☐ Bursitis
- ☐ Buttock pain
- ☐ Cancer _____
- ☐ Carpal tunnel syndrome
- ☐ Chest pain
- ☐ Colic (baby)
- ☐ Constipation
- ☐ Cochlear Implant _____
- ☐ Diabetes _____
- ☐ Diaphragm pain or tightness
- ☐ Diarrhea _____
- ☐ Dizziness
- ☐ Ear or eye problem
- ☐ Edema/swelling_____
- ☐ Elbow pain, tennis or golf
- ☐ Fatigue, chronic
- ☐ Fibromyalgia or polymyalgia
- ☐ Fibroids -- (location):_____
- ☐ Fracture(s) _____
- ☐ Fallen on tailbone / coccyx
- ☐ Gall bladder problem
- ☐ Heating pad / ice pack usage
- ☐ Heating / cooling salve usage
- ☐ Hammer toes
- ☐ Hamstring pain or tightness
- ☐ Headaches
- ☐ Heart problems
- ☐ Hernia
- ☐ Hip pain
- ☐ Hip replacement
- ☐ Implant(s)
- ☐ Incontinence / bladder (adult)
- ☐ Infertility
- ☐ Jaw / TMJ problem / **Surgery**?
- ☐ Joint replacement -- (location):
- ☐ Knee problem
- ☐ Liver problem
- ☐ Lung problem
- ☐ Magnet usage
- ☐ Menopause: pre☐ in☐ post☐
- ☐ Migraines
- ☐ Neck Pain
- ☐ Numbness (where):
- ☐ Orthodontia, extensive
- ☐ Orthotics in shoes??
- ☐ Osteoporosis
- ☐ Pain: (location):
- ☐ Pelvic pain
- ☐ Plantar fasciitis or neuroma
- ☐ PMS or menopause
- ☐ Pregnancy or actively trying
- ☐ Prolapse
- ☐ Prostate problem
- ☐ Rib pain / subluxation
- ☐ Scars
- ☐ Sacral pain
- ☐ Sciatica
- ☐ Scoliosis
- ☐ Shin splints
- ☐ Shoulder problem
- ☐ Sinus problem
- ☐ Sleep / energy problems
- ☐ Tail-bone injury
- ☐ Tinnitus
- ☐ Uterine or ovary problem
- ☐ Urination problem
- ☐ Vehicular accidents
- ☐ Wrist or thumb pain
- ☐ Bladder/urine flow

Check the area(s) of pain on the anatomical drawing and **rate the severity of each pain** on a scale of 1-10 to the best of your ability. Or color/shade your painful or problem areas…



(2) Mild pain (annoying, nagging)
(4) Discomforting (troublesome, numbing)
(6) Distressing (miserable, agonizing, gnawing)
(8) Intense (cramping, dreadful, horrible)
(10) Excruciating (tearing, crushing, unbearable)
(N) Numb areas

Current medications, herbals: (State it's purpose, such as cholesterol, high blood pressure, osteoporosis). This helps us help you better or may, in rare cases, indicate potential medical referral. **Beware that Opioids (narcotics) and anti-depressants can inhibit/slow down the speed of success of Bowenwork.** IF possible, take minimal doses before a session with us.

_____, _____, _____
_____, _____, _____
_____, _____, _____
_____, _____, _____
_____, _____, _____

Name any hands-on modalities/therapies/treatments you have had and how recently. This includes but is not limited to Chiropractic, Massage, Acupuncture, Physical Therapy, etc.

_____,_____

_____,_____

_____,_____

** I have stated, to the best of my knowledge, my known medical conditions. I understand that Bowenwork is given to me 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 if I have any concerns. **

Your Name:
****Print/Signature** _____, _____ **Date** _____

* * * * * * * done * * * * * * * *

To be completed by practitioner (As it applies to your care)**:**

Range of Motion:

Neck turn (R) _____(L) _____ Arm out (R) _____(L) _____

Arm forward (R) _____(L) _____ Height _____

Scapula 'Stop' (R) _____(L) _____ Psoas knee position (R) _____(L) _____

Leg extension (R) _____(L) _____ Leg abduction (R) _____(L) _____

Faber ROM (R) _____(L) _____ Faber Pain: Groin_____Buttock_____

Balance _____ Balance- eyes closed _____

Balance- Right leg _____ Balance- left leg _____