

Client Intake Form

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ ZIP: _____

Email: _____ Phone: _____

Reason for Visit: _____

Referred by: _____ Phone: _____

Contact in Case of Emergency: _____ Phone: _____

General & Medical Information:

Occupation: _____ Age: _____ female male

Sports/Hobbies/Activities: _____

Physician: _____ Phone: _____

Yes No Have you had a massage and /or chiropractic treatment within the last 3 days?

If you answer "yes" to any of the following questions, please explain as clearly as possible.

Yes No Do you frequently suffer from stress?

Yes No Do you have diabetes?

Yes No Do you experience Migraines?

If yes: How often? _____

Duration? _____

Symptoms? _____

Yes No Do you have high blood pressure?

Yes No Are you pregnant?

Yes No Have you ever given birth?

Yes No Do you have any problems with your feet?

Yes No Do you suffer from joint swelling?

Yes No Do you suffer from epilepsy or seizures?

Yes No Do you have varicose veins?

Yes No Do you have elbow / wrist pain?

Yes No Do you have any digestive problems?

Yes No Do you grind your teeth?

Yes No Do you have shoulder problems?

Yes No Do you have any contagious diseases?

Yes No Have you been diagnosed with Fibromyalgia,
Chronic Fatigue, or MS?

Yes No Do you bruise easily?

Yes No Do you experience frequent headaches?

Yes No Have you been in an accident or suffered any injuries
in the past two years?

Yes No Do you have tension or soreness in any specific area?
Please specify: _____

Yes No Do you have cardiac or circulatory problems?

Yes No Do you suffer from back pain?

Yes No Do you have numbness or stabbing pains anywhere?
Where? _____

Yes No Are you sensitive to touch or pressure in any area?
Where? _____

Yes No Have you had surgery in the past 5 years? Explain below.

Yes No Do you have any other medical condition that I should know
about? _____

Yes No Do you have ringing in your ears?

Yes No Do you have any knee pain or swelling?

Yes No Do you have osteoporosis?

Yes No Do you have allergies? To what?

Please list any injuries/accidents, and the date of occurrence, you have had:

Please list any surgeries, and the date of occurrence, you have had:

Please list any medications you are currently taking – and the reason:

Please list any X-Ray/MRI/CAT Scan diagnostic report results:

Comments: _____

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

I understand that Bowenwork Therapy should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician or other qualified medical specialist for any medical or physical ailment that I am aware of. I understand that Bowenwork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner’s part should I fail to do so.

Client Signature: _____ Date: _____

Practitioner Signature: _____ Date: _____

Consent to Treatment of Minor: By my signature below, I hereby authorize Hans (Klaus) Levy to administer Bowenwork Therapy to my child or dependent, as he deems necessary.

Signature of Parent or Guardian: _____ Date: _____