Austin Bowenwork™ and Alignment Center

Holistic Body-Soul Healing
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New Client Health Intake Form

Welcome to our practice. Get ready to experience a different and effective approach to health and healing. Please fill out the following form and if you have any questions, please feel free to ask.

Name_____ Date_____

Address_____City_____State_____Zip_____

Phone (home) _____ (work) _____ (cell) _____

Date of Birth_____ Age_____ Email_____
Who can we thank for referring you? _____
Occupation_____Employer's Name_____
Spouse or Parent Name_____ Phone# _____
Emergency Contact_____Phone#_____
Primary Medical Doctor_____Phone#_____
Do you wish to receive our online newsletter (promotions, health info, practice updates)?
YES NO

Please answer the following questions about your health:

What health challenges bring you into the office today?_____
_____
_____
What are your goals for today's visit? _____
_____
_____
What therapies are you <u>currently</u> using? _____
_____
What therapies have you utilized in the <u>past</u>? _____
_____
Have you ever suffered any serious injuries or trauma, been hospitalized, or had surgery? If yes, briefly describe: _____
_____
Have you ever fallen and/or injured your tailbone? If yes, please describe:_____
_____
_____
Are you presently under a medical practitioner's care? If yes, briefly describe:_____
_____
Do you exercise regularly? If yes, briefly describe: _____
_____
_____

Please circle <u>CURRENT</u> symptoms/conditions that apply to you

Headache
Migraine
Tension/Stress
Hormonal
TMJ headaches
Other _____

Opthalmic
Eye pain/weakness
Tearing
Puffy Eye Lids
Red, congested
Other _____

Otologic
Fluid in the ears
Ringing in ears
Meniere's Syndrome
Vertigo
Other _____

Respiratory
Asthma
Cough
Bronchitis
Difficulty Breathing
Allergies
Other _____

Cardiovascular
Irregular Heart Beat
Palpitations
Fainting

Hot Flashes
Night Sweats
Chest Pain
Other _____

Gastrointestinal
Food Intolerances
Nausea
Vomiting
Heartburn
Indigestion
Abdominal Pain
Bloating
Diarrhea
Irritable Bowel
Other _____

Musculo-Skeletal
Muscle Spasms
Muscle Pain
Sluggishness
Backache
Sciatica
Bursitis
TMJ Syndrome
Tendonitis
Scoliosis
Arthritis Osteo or Rheumatoid
Joint Swelling
Joint Stiffness
Bone Spurs
Disc Herniation

Cerebral
Restlessness
Insomnia
Anxiety
Hyperactivity
ADD
Other _____

Urological
Frequency / Urgency
Painful Urination
Urination at night
Poor bladder control
Other _____

Auto Immune
Lupus
Multiple Sclerosis
Fibromyalgia
Chronic Fatigue Syndrome
Lou Gehrig's

Other_____

Personal Status Report (Please answer "yes" or "no" and describe)

Yes No

- □ □ Do you have any skin problems or allergies? If yes, please describe:_____
  _____
- □ □ Do you have or have you ever had heart problems? If yes, please describe: _____
  _____
  _____
- □ □ Do you have or have you ever had cancer? If yes, please describe: _____
  _____
- □ □ Do you have high or low blood pressure? If yes, circle one
- □ □ Do you have varicose veins, blood clots, or any other circulatory conditions? If yes, please describe: _____
- □ □ Do you have diabetes? If so, how is it controlled? _____
- □ □ Are you pregnant? If so, what stage? _____
- □ □ Do you wear contact lenses or dentures? _____
- □ □ Are you currently taking any medications? If so please list and describe what you're taking them for: _____
  _____
  _____
- □ □ Are you taking any vitamins, supplements or herbs? Please list:_____
  _____
  _____
- □ □ Are you sensitive or allergic to any foods? If so, please name:
  _____
  _____
- □ □ Do you have any special needs or anything else we need to be made aware of?
  _____

Please rate your current LEVEL of health by circling the number that best corresponds to how you feel:

Physical

1 2 3 4 5 6 7 8 9 10

Low High

Little to no exercise, poor diet, poor sleep, I'm in pain — Very little pain, Exercise daily, meditate, excellent diet, great sleeper

Mental

1 2 3 4 5 6 7 8 9 10

Low High

I'm a worrier and my brain is always working — I can let go of stress and turn my brain off easily

Emotional

1 2 3 4 5 6 7 8 9 10

Low High

I hold my feelings in and feel sad inside often, don't feel supported — I feel fully expressed, supported, and joyful in my heart

Spiritual

1 2 3 4 5 6 7 8 9 10

Low High

I'm not living my life purpose, I feel stuck — I am living a purposeful and meaningful life

AUSTIN BOWENWORK CENTER WAIVER AND POLICIES

* I understand that Bowenwork and Restorative Exercise is for the purpose of pain relief, stress reduction, relief from muscular tension and spasm, improvement of circulation, energy, alignment and lymphatic flow.

* In a strictly medical sense, Bowenwork Therapy/Restorative Exercise doesn't cure anything. It allows the body to heal itself the way it is designed to.

* I understand the Bowenwork Practitioner doesn't diagnose illness, disease, or any physical or mental disorder. The practitioner does not prescribe medical treatment or pharmaceuticals, nor does he/she perform any spinal manipulation. It has been made clear that the BowenWork Practitioner is not a substitute for medical examination or diagnosis and that it is recommended that I see a medical doctor for any physical ailment that I may have.

* I understand that services offered today, and in the future, are not a substitute for medical care and that any information provided by the therapist is for education purposes only, and is not diagnostically prescriptive in nature.

* I have stated all of my known medical conditions on the intake form.

* I realize it is solely my responsibility to keep the BowenWork Therapist updated on any changes in my physical health and I understand that AUSTIN BOWENWORK CENTER and the practitioners shall not be liable should I fail to do so.

* I agree to actively participate, as much as possible in my own healing and health maintenance.

I understand the above statements, and have read and agree to the policies therein.

Today's Date:_____ Client Signature:_____
Parent/Guardian Signature: _____