

Calm Energy Wellness

Bowenwork® Intake Form

First Name: _____ Last Name: _____

Date of Birth: _____ Sex: _____ Age: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email address: _____

Preferred to be contacted by: _____ Emergency Contact Name: _____

____ Phone ____ Email ____ Text or ____ Any Emergency Contact Phone: _____

Referred by: _____ Emergency Contact Relation: _____

Hobbies/sports/activities: _____

Are you pregnant (Y/N): _____ Medications/allergies: _____

Previous Operations/Accidents/Illnesses (Please include specific dates and details):

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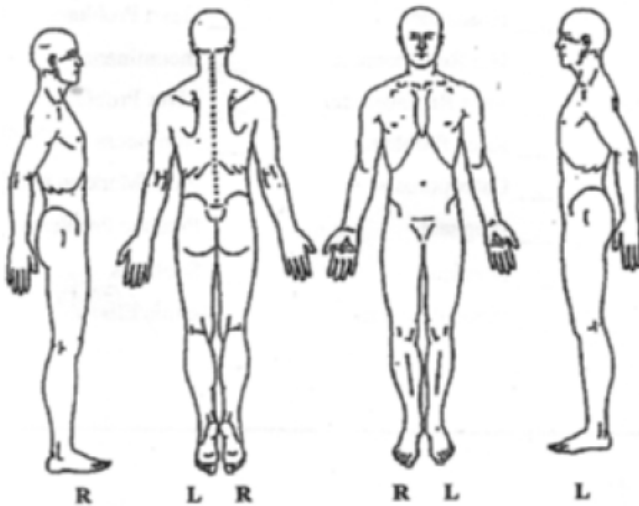
Please check all that apply:

| | | |
|---|---|---|
| <input type="radio"/> Abdominal / digestive problems | <input type="radio"/> Ear or eye problem | <input type="radio"/> Magnet usage |
| <input type="radio"/> Allergies / hay fever | <input type="radio"/> Edema (body swelling location): | <input type="radio"/> Migraines |
| <input type="radio"/> Arthritis - (location): | <input type="radio"/> _____ | <input type="radio"/> Numbness - (location): |
| <input type="radio"/> _____ | <input type="radio"/> Elbow pain, tennis or golf | <input type="radio"/> _____ |
| <input type="radio"/> Asthma | <input type="radio"/> Fatigue, chronic | <input type="radio"/> Orthodontia, extensive |
| <input type="radio"/> Ankle problem | <input type="radio"/> Fibromyalgia or polymyalgia | <input type="radio"/> Orthotics in shoes |
| <input type="radio"/> Back pain - (location): | <input type="radio"/> Fibroids - (location): | <input type="radio"/> Osteoporosis |
| <input type="radio"/> _____ | <input type="radio"/> _____ | <input type="radio"/> Pain, other - (location): |
| <input type="radio"/> Bed wetting (children) | <input type="radio"/> Fracture | <input type="radio"/> _____ |
| <input type="radio"/> Bone spurs | <input type="radio"/> Fallen on tailbone / coccyx | <input type="radio"/> Pelvic pain |
| <input type="radio"/> Breast lump | <input type="radio"/> Gall bladder problem | <input type="radio"/> Plantar fascitis or neuroma |
| <input type="radio"/> Breast pain | <input type="radio"/> Heating pad / ice pack usage | <input type="radio"/> (pinched nerve on foot) |
| <input type="radio"/> Breast implants | <input type="radio"/> Heating /cooling salve usage | <input type="radio"/> PMS or menopause |
| <input type="radio"/> Bronchitis | <input type="radio"/> Hammer toes | <input type="radio"/> Pregnancy |
| <input type="radio"/> Bunion | <input type="radio"/> Hamstring pain or tightness | <input type="radio"/> Prostrate problem |
| <input type="radio"/> Bursitis | <input type="radio"/> Headaches | <input type="radio"/> Rib pain / subluxation (misaligned vertebrae) |
| <input type="radio"/> Buttock pain (local, not radiating) | <input type="radio"/> Heart problem | <input type="radio"/> Sacral pain |
| <input type="radio"/> Cancer | <input type="radio"/> Hernia | <input type="radio"/> Sciatica |
| <input type="radio"/> Carpal tunnel syndrome | <input type="radio"/> Hip pain | <input type="radio"/> Scoliosis |
| <input type="radio"/> Chest pain | <input type="radio"/> Hip replacement | <input type="radio"/> Shin splints |
| <input type="radio"/> Colic (baby) | <input type="radio"/> Incontinence / bladder (adult) | <input type="radio"/> Shoulder problem |
| <input type="radio"/> Constipation | <input type="radio"/> Infertility | <input type="radio"/> Sinus problem |
| <input type="radio"/> Diabetes | <input type="radio"/> Jaw / TMJ problems | <input type="radio"/> Sleep / energy problem |
| <input type="radio"/> Diaphragm pain or tightness | <input type="radio"/> Joint replacement | <input type="radio"/> Tinnitus |
| <input type="radio"/> Diarrhea | <input type="radio"/> Knee problem | <input type="radio"/> Uterine or overay problem |
| <input type="radio"/> Dizziness (accident-explain?): | <input type="radio"/> Liver problem | <input type="radio"/> Wrist or thumb pain |
| <input type="radio"/> _____ | <input type="radio"/> Lung problem | <input type="radio"/> Other Not Listed |

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Mark site(s) of pain on the anatomical drawing and rate the severity of each pain on a scale of 1-10 -

Range of Motion completed by Practitioner



| |
|----------------------|
| Neck ROM: |
| L |
| R |
| TMJ: |
| Shoulder ROM: |
| L |
| R |

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)

Current condition(s) and activities compromised by them:

Prior Treatment for presenting Condition(s):

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

Other relevant information:

I have stated, to the best of my knowledge, my known medical conditions. I understand that Bowenwork® 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 diseases, 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.

Late Arrival Appointment Policy:

A client with a designated appointment has the opportunity during their scheduled time to receive service. If you are late arriving for your scheduled appointment, I will begin your service as soon as you arrive to accommodate the best service, but must finish according to the accommodation and respect of other clients that have scheduled appointments.

Cancellation/Rescheduling/Payment Policy:

I understand there are times when you need to cancel and/or reschedule an appointment due to emergencies. As a courtesy, please kindly contact me by phone either call or text to give me a 24 hour notice of cancellation or rescheduling to avoid a \$50 fee. A payment is required to be submitted at the time of your session. Insurance is not available. Your appointment time is reserved exclusively for you and I request that you please review and respect the cancellation policies.

Privacy Policy: *Calm Energy Wellness will not release your records to anyone unless your written consent*

Print Name (Parent or Guardian)

- ☐ I acknowledge these policies
- ☐ Allow Calm Energy Wellness to send you communication

Signature (Parent or Guardian)

Date