Rejeneration

Bowen Therapy – Health History

All information gathered for this treatment is confidential, and for the use of the therapist alone.

Name: _____ Date: _____

Address: _____ Postal Code: _____

Telephone: home: _____ office _____ Date of Birth: _____

Occupation: _____ Who referred you? _____

Email:_____

Health History: Please indicate conditions you are experiencing, or have experienced:

- chronic cough
- shortness of breath
- bronchitis
- asthma
- depression
- poor circulation
- migraines
- ^ TMJ or jaw pain
- difficult digestion
- liver
- gall bladder
- skin conditions _____
- kidney
- insomnia
- loss of sensation
- diabetes (onset: _____)
- allergies (i.e. Anaphylaxis) or skin irritation
- cancer type: _____
- back pain
- ^ tailbone injury or pain
- vision problems
- vision loss
- ear problems
- hearing loss
- bladder
- fibromialgia
- high blood pressure
- low blood pressure
- gynaecological issues
- heart attack- date: _____
- stroke / CVA
- angina
- hepatitis
- breast tenderness/fibroids
- TB
- HIV
- sport injuries
- chronic fatigue syndrome

Other Medical Conditions: (e.g. digestive, haemophilia, etc.): _____

Of Special Note: (presence of internal pins, wires, artificial joints, special equipment): _____
_____

Current Medications: _____

Current Health Care: i.e.) physiotherapy, massage therapy, chiropractic. Yes No

Indicate any previous injuries: _____

_____

Soft Tissue / Joint Discomfort :
Have you had a previous injury? If so please explain_____

Have you ever been in a car accident? If so what was the impact? _____

Primary Complaint

Area affected: (e.g. right leg)_____ When did it begin? _____

Can you describe the pain? □ sharp □dull □ constant □ come and go □ numbness or tingling
□ swelling □ does it radiate? □ weakness □ other?

Does anything make it better or worse?

	Better	Worse	Describe
Activity	□	□	_____
Heat	□	□	_____
Cold	□	□	_____
Rest	□	□	_____
Sitting	□	□	_____
Standing	□	□	_____

Is there anything else that may be of importance regarding your injury or problem?
_____
_____

Secondary Complaint

Area affected: (e.g. right leg)_____ When did it begin? _____

Can you describe the pain? □ sharp □dull □ constant □ come and go □ numbness or tingling
□ swelling □ does it radiate? weakness □ other?

Does anything make it better or worse?

	Better	Worse	Describe
Activity	□	□	_____
Heat	□	□	_____
Cold	□	□	_____
Rest	□	□	_____
Sitting	□	□	_____
Standing	□	□	_____

Is there anything else that may be of importance regarding your injury or problem?
_____
_____

Is there anything else that can be done to make this appointment more comfortable for you?
_____

Signature: _____ Date: _____

We Also

Neuromuscular Therapy (The Bowen Technique)
Cancer Exercise Specialty & Cancer Recovery Complimentary Care Services