

# BOWENWORK WELLNESS CLINIC

Assessment ♦ Release ♦ Healing

## Bowen Intake Form

TODAY'S DATE: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

NAME (full): \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

Yes, please email me occasional newsletters and special offers. *Note: We will never sell or share your contact information.*

SUBSCRIBER'S NAME (if different) \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ MARITAL STATUS: M D S W P

SPOUSE / PARTNER NAME: \_\_\_\_\_

SPOUSE'S EMPLOYER \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ PHONE: \_\_\_\_\_

### BILLING INFORMATION

PATIENT SOC SEC NUMBER: \_\_\_\_\_ DOB \_\_\_\_\_

SUBSCRIBER'S SSN: \_\_\_\_\_ DOB \_\_\_\_\_

INSURANCE COMPANY: \_\_\_\_\_ PLAN NAME: \_\_\_\_\_

INSURANCE ADDRESS: \_\_\_\_\_

ID NUMBER: \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_

#### AUTHORIZATIONS AND AGREEMENT OF PAYMENT

I understand that payment is due at the time of my visit. I hereby authorize direct payment to Scott Wurtz LMP RBT for services provided to me at the Bowenwork Wellness Clinic from my insurance company. I also authorize release of any medical records that may be necessary for either medical care or processing of benefits. I understand it is my responsibility to know and understand my insurance policy and benefits. I acknowledge that I am responsible for co-pays, deductibles or services not covered by my insurance.

PATIENT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**HEALTH HISTORY PROFILE**

NAME: \_\_\_\_\_

FAMILY PHYSICIAN: \_\_\_\_\_

WHOM CAN WE THANK FOR REFERING YOU: \_\_\_\_\_

What health concern(s) motivated you to come in today:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How long ago did this condition begin - please be as specific as possible:

\_\_\_\_\_

How does this condition interfere with your life (activities, sleeping etc):

\_\_\_\_\_  
\_\_\_\_\_

Have you been given a diagnosis for this condition, if so what:

\_\_\_\_\_

What kinds of treatments have you received for this condition(s)?

\_\_\_\_\_

Have you had any surgeries, what kind: \_\_\_\_\_

\_\_\_\_\_

Please list all significant traumas (auto accidents, etc.) \_\_\_\_\_

\_\_\_\_\_

Your Occupation: \_\_\_\_\_

What do you feel are your occupational stresses (chemical, physical, emotional)?

\_\_\_\_\_

Please describe any exercise program you do and at what frequency:

\_\_\_\_\_

Please list any regular medications you are taking, including vitamins, herbs, and over the counter drugs: \_\_\_\_\_

\_\_\_\_\_

## DIET AND LIFESTYLE QUESTIONS

NAME: \_\_\_\_\_

How much do you smoke each day \_\_\_\_\_? Do you use tobacco in a form other than smoking \_\_\_\_\_?

How much alcohol do you drink each day or week \_\_\_\_\_/d \_\_\_\_\_/wk

Please describe any drug use for non-medical purposes: \_\_\_\_\_

How many beverages do you drink each day? cups of tea/d \_\_\_\_\_ cups of coffee/d \_\_\_\_\_

colas, Gatorade, power drinks/d \_\_\_\_\_ glasses of milk/d \_\_\_\_\_

Do you eat mostly organic foods? \_\_\_\_\_ Do you mostly cook at home or dine out? \_\_\_\_\_

Please describe your average daily foods eaten:

Morning: \_\_\_\_\_

Afternoon: \_\_\_\_\_

Evening: \_\_\_\_\_

Do you chew gum on a regular basis? \_\_\_\_\_

On average, how many ½-cup servings of vegetables each day: \_\_\_\_\_

On average, how many ½-cup servings of fruits each day: \_\_\_\_\_

How much water do you drink each day (ounces): \_\_\_\_\_

Are you concerned about getting enough nutrients from your diet? \_\_\_\_\_

NAME: \_\_\_\_\_

Please check any symptoms or statements that you agree describe your current experience. All the information is useful in developing a comprehensive picture of health. Thank you.

**Energy and sleep and spirit:**

- my energy is good, I can do everything I want to
- I feel rested when I wake up
- I don't have good energy
- I often have weakness, lethargy
- other: \_\_\_\_\_

**Gastrointestinal Health:**

- poor appetite
- healthy appetite
- excessive appetite, hunger
- heartburn or reflux
- much gas or flatulence, bloating
- other: \_\_\_\_\_

**Skin:**

- itching skin/scalp
- eczema
- acne
- rashes
- warts or moles
- other: \_\_\_\_\_

**Muscular Skeletal System:**

- muscles feel weak
- morning stiffness or pain
- joint pain (which \_\_\_\_\_)
- chronic low back pain
- recent low back pain
- recent neck pain
- other pain
- numbness or tingling of hands, feet
- radiating pain
- foot pain
- muscle cramps in legs
- stabbing or throbbing pains
- tension or pain in shoulders
- other: \_\_\_\_\_

**Metabolic:**

- decline of memory
- weight gain of concern
- weight loss of concern
- sensitive to chemicals
- dizziness
- unsteady when getting up
- easily fatigued
- fatigue after exercise
- easily chilled
- intolerant to temperature changes
- low blood sugar (faint, drop in energy)
- diabetes (or in family)
- other: \_\_\_\_\_

**Ear, Nose and Throat:**

- shortness of breath
- earaches
- chronic congestion
- recurrent sinusitis
- headaches
- migraines
- dry or red eyes
- ringing in ears
- frequent colds or coughs
- season allergies
- asthma
- shortness of breath
- blurring of vision
- loss of hearing
- puffiness around eyes
- other: \_\_\_\_\_

NAME: \_\_\_\_\_

**Women's Health:**

started menses at age \_\_\_\_\_  
date/age when stopped menses \_\_\_\_\_  
first day of last menses \_\_\_\_\_  
date of last PAP \_\_\_\_\_  
number of pregnancies \_\_\_\_\_  
number of days in cycle \_\_\_\_\_  
\_\_\_ spotting in between menses  
\_\_\_ heavy menstruation  
\_\_\_ menstrual cramps  
\_\_\_ menstrual clots  
\_\_\_ recurrent vaginitis  
\_\_\_ hot flashes or night sweats  
other: \_\_\_\_\_

**Men's Health:**

date of last physical \_\_\_\_\_  
\_\_\_ pain in groin  
\_\_\_ hernias  
\_\_\_ pain in testicle  
\_\_\_ mass or swollen testicles  
\_\_\_ difficulty initiating urination  
\_\_\_ slow, thin stream of urination  
\_\_\_ premature ejaculation  
\_\_\_ erectile dysfunction  
date of last PSA test \_\_\_\_\_  
\_\_\_ urethral soreness/itching  
\_\_\_ prostatitis or hypertrophy  
other: \_\_\_\_\_

**Urinary:**

\_\_\_ frequent urination  
\_\_\_ night urinations (#/times \_\_\_\_\_)  
\_\_\_ incomplete voiding  
\_\_\_ urinary urgency  
\_\_\_ incontinence  
\_\_\_ chronic bladder  
\_\_\_ infections  
other: \_\_\_\_\_

**Cardiovascular:**

\_\_\_ high blood pressure  
\_\_\_ tightness in chest  
\_\_\_ murmur  
\_\_\_ pain in the chest  
\_\_\_ palpitations, irregular beats  
\_\_\_ cold hands and feet  
\_\_\_ mitral valve prolapse  
other: \_\_\_\_\_

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

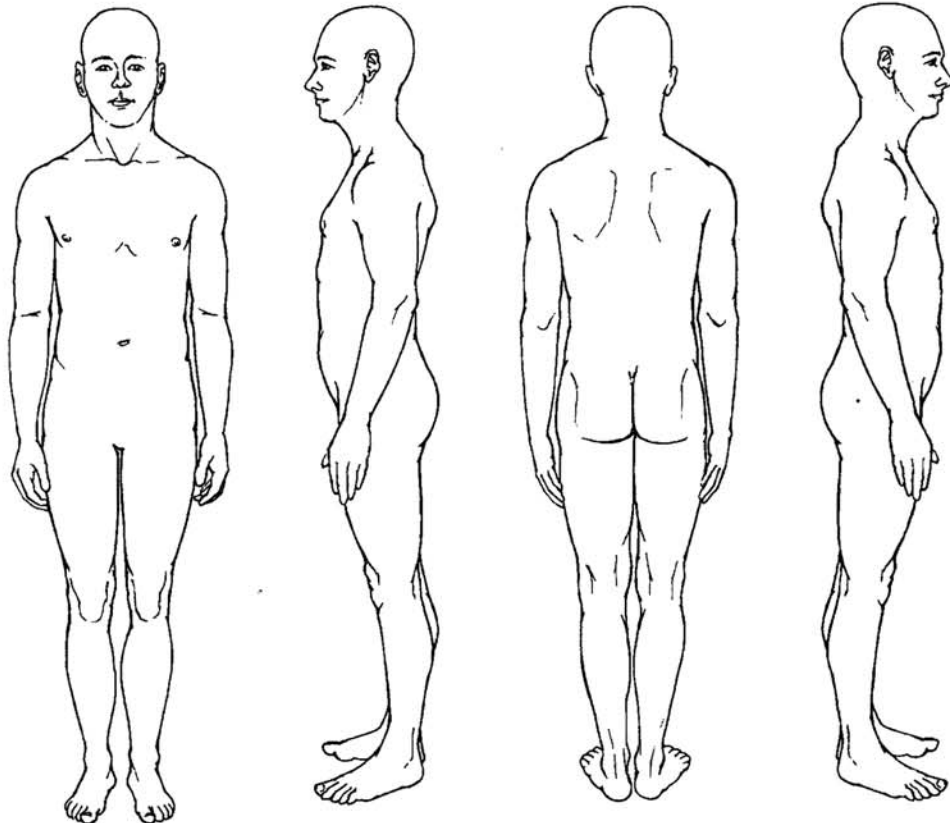
Date of Injury \_\_\_\_\_ ID#/DOB \_\_\_\_\_

**A. Draw today's symptoms on the figures.**

1. Identify CURRENT symptomatic areas in your body by marking letters on the figures below. Use the letters provided in the key to identify the symptoms you are feeling today.
2. Circle the area around each letter, representing the size and shape of each symptom location.

**Key**

- P = pain or tenderness
- S = joint or muscle stiffness
- N = numbness or tingling



**B. Identify the intensity of your symptoms.**

1. Pain Scale: Mark a line on the scale to show the amount of pain you are experiencing today.

No Pain |-----| Unbearable Pain

2. Activities Scale: Mark a line on the scale to show the limitations you are experiencing today in your daily activities.

Can Do Anything I Want |-----| Cannot Do Anything

**C. Comments**

---



---



---



---

Signature \_\_\_\_\_ Date \_\_\_\_\_