B-WELL BOWENWORK®

Consent Form

THIS FORM MUST BE COMPLETED and SIGNED BEFORE RECEVING A TREATMENT.

General and Medical Information

Name: _____ Date: _____

Street/Mailing Address: _____

City: _____ Postal Code: _____

Home Telephone: _____ Cell Phone: _____

Date of Birth: M _____ / D _____ / Y _____ Age: _____ Sex: M / F

Email Address: _____

Have you ever receive a professional Bowen treatment? Yes ☐ No ☐

Which areas would you like to focus on during this treatment?

_____

_____

Occupation: _____

Medical/Naturopathic Doctor: _____

Consent to inform your Medical Doctor or Naturopath? Yes ☐ No ☐

How did you hear about Bowenwork? _____

1. Place a check mark if you suffer from any of the following:

☐ diabetes	☐ migraines	☐ breast implants
☐ joint replacement	☐ tension headaches	☐ depression
☐ heart problems	☐ skin disease	☐ wear contact lenses
☐ kidney disease	☐ digestive issues	☐ epilepsy or seizures
☐ high blood pressure	☐ infectious disease	☐ back pain
☐ respiratory disease	☐ joint or muscle injuries	☐ angina
☐ areas of numbness	☐ areas of chronic pain	☐ pregnant
☐ paralysis	☐ tail bone injury	

2. Are you taking medication? Yes ☐ No ☐

If yes, please list:

_____

_____

_____

3. Indicate which muslces in your body usually suffer from (T) tension, (S) Stiff or sore (C) cramping.

☐ back	☐ arms	☐ wrists
☐ neck	☐ chest	☐ hips
☐ shoulder	☐ legs	☐ jaw
☐ hands	☐ feet	

4. Please tell me about your condition:

_____

_____

_____

5. Previous treatment from other health care professionals. Did you see improvement? Please specifiy.

_____

_____

6. Please list any accidents, trauma, or surgeries.

_____

_____

7. List any other conditions not mentioned:

_____

_____

Bowenwork the original Bowen Therapy is contraindicated under certain conditions; I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I forget to do so.

I understand that Bowen therapists are not qualified to perform skeletal adjustments, diagnose and/or prescribe, and that nothing said in the course of the session should be construed as such.

Patient's signature: _____ Date: _____

Name: _____

(Please print)