Wellness Restoration Arts
Assessment • Release • Healing

New Client Health Intake Form

Welcome to Wellness Restoration Arts
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 #_____

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 currently using? _____
_____
What therapies have you utilized in the past? _____
_____
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 tail bone? If yes, please describe:_____
_____

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Are you currently taking any medications or supplements? If so please list and describe what you're taking them for: _____

_____

Are you presently under a medical practitioner's care? If yes, briefly describe:_____

_____

Do you exercise regularly? If yes, briefly describe: _____

_____

PLEASE CIRCLE **CURRENT** SYMPTOMS/CONDITIONS THAT APPLY TO YOU:

Headache
Migraine
Tension/Stress

Opthalmic
Eye pain
Tearing
Puffy Eye Lids
Red, congested blood-vessels

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

Respiratory
Asthma
Cough
Bronchitis
Difficulty Breathing
Allergies

Cardiovascular
Irregular Heart Beat
Palpitation
Fainting
Hot Flashes
Night Sweats
Chest Pain

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

Muscular
Muscle Spasms
Muscle Pain
Sluggishness
Backache
Sciatica
Bursitis
TMJ Syndrome
Tendonitis

Skeletal
Scoliosis
Arthritis Osteo or Rheumatoid
Joint Swelling
Joint Stiffness
Bone Spurs

Cerebral Stimulation
Restlessness
Insomnia
Anxiety
Hyperactivity
ADD

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

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

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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, check 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?
☐	☐	Do you have any special needs or anything else we need to be made aware of?

Mark diagram for areas of:

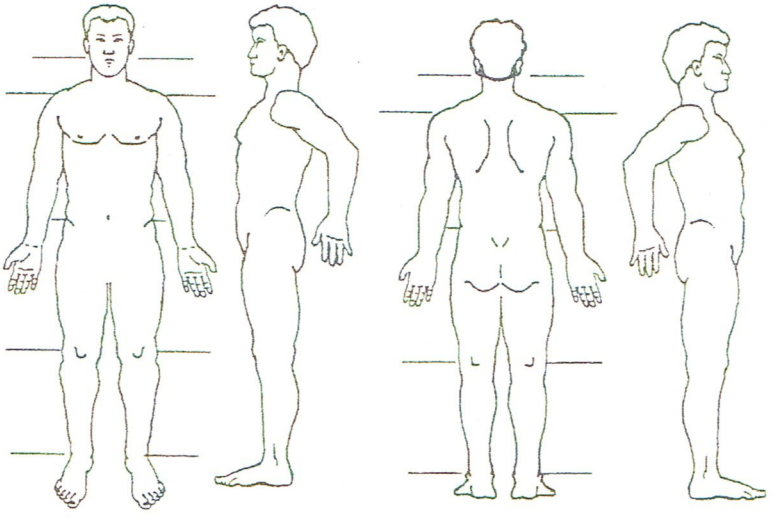
Pain

Spasm

Tension

Surgery

Injuries XXX



PAIN SCALE

0 = No pain
1 = Slight pain
2
3 = Mild pain
4
5 = Moderate pain
6
7 = Severe pain
8
9 = Very severe pain
10 = Worst pain possible

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Wellness Restoration Arts WAIVER AND POLICIES

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

In a strictly medical sense, Bowenwork Therapy 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 Blue Fire Bowenwork 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 well-being.

Office Policies:
Please initial

_____ I understand that I will be charged a $50 cancellation fee if I do not call at least 24 hours in advance to cancel or reschedule my appointment. Please have a friend or family member take your appoint ment if you are unable to make it the day of your session.

_____ I agree to turn off or silence my CELL PHONE/PAGER upon entering.

_____ I understand that if I do not comply with office policies and do not actively partake in my treatment plan, Wellness Restoration Arts reserves the right to discontinue my care.

I understand the policy statement, and have read and agree to the policies therein.

Today's Date:_____ Client Signature:_____

Parent/Guardian Signature: _____