Consultation Form

Name: ..... Client No: .....

Address: ..... Telephone No: Day: .....

..... Evening: .....

..... Mobile: .....

..... Post Code: .....

GP Name & Address: ..... Email: .....

..... Sex: M ☐ F ☐

GP Telephone No: ..... Date of Birth: .....

How did you hear about me? (*e.g. word of mouth, website, newspaper, local radio.)*

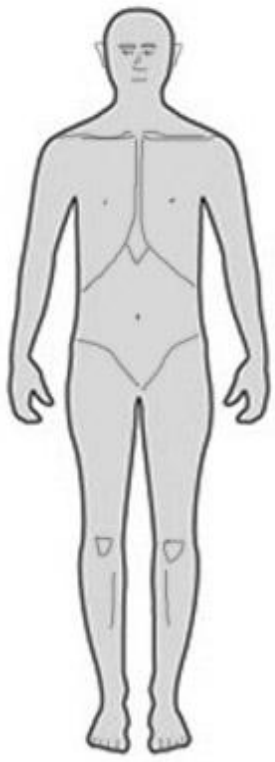
– ***PAIN CHART*** +

1 2 3 4 5 6 7 8 9 10

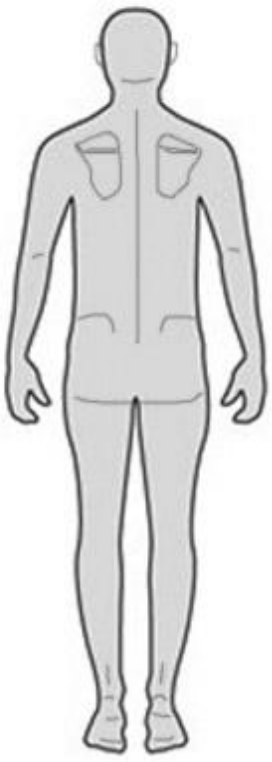
Please mark in red *(if possible)* your area/s of pain.

Put an arrow beside each one with a pain scale of 1 to 10,

e.g. if you have headache you may rate the pain 5/10.
If the pain is variable, you may choose to rate it 3-5/10.



FRONT



BACK

Reason for treatment:

Continued.../

Physical Health

Do you have any current medical problems?
Are you currently being treated by another therapist for any problems?
Do you suffer from any current skin problems? *(i.e. Psoriasis, eczema, acne,)*
Do you have any allergies, suffer from hay fever or have asthma?
Could you be pregnant? Yes / No *If yes, how many weeks/months?* Do you have any past pregnancies? Yes / No *If yes, how many and how long ago.* Were there any complications with the birth/s?
Have you had any operations in the last 6 months?
Have you ever had any major illnesses or operations? *(including Dental surgery, Hip replacement, Breast implants)*
Have you had any injuries? *(e.g. fallen off bike, down stairs)*
Any relevant family medical history?
Do you have any medical conditions that may make you very poorly very quickly? *e.g. epilepsy.* If so, how would you need me to respond?

Do you, or have you ever, suffered from any of the following *(if yes, please give more detail in the area at the bottom of this list)*:		
Rheumatism, arthritis, gout	Yes	No
Osteoporosis	Yes	No
Stiff joints, aches or pain	Yes	No
Recurrent infections*(e.g. Ear, sinuses)*	Yes	No
Undiagnosed lumps or bumps	Yes	No
Water retention/swollen limbs	Yes	No
Constipation	Yes	No
Stomach or digestive problems	Yes	No
Bowel problems	Yes	No
High/low blood pressure	Yes	No
Heart problems	Yes	No
Varicose veins	Yes	No
Problem periods	Yes	No
PMT	Yes	No
Menopause	Yes	No
Migraines or headaches	Yes	No
Stress	Yes	No
Depression	Yes	No
Epilepsy	Yes	No
Diabetes	Yes	No
Cancer	Yes	No
Areas of undiagnosed pain	Yes	No
Further information:		

Current medication *(Doctors and any complementary medications)*

Name of Drug	Dose	Frequency	Since when

Continued.../

Lifestyle

Stress Levels	
– ***At home*** +	– ***At work*** +
1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10

What is your occupation *(it does not need to be paid)*?

How much free time do you have per week?

What are your hobbies or creative interests?

How would you define your sleep pattern? *(e.g. how many hours per night)*

Do you snore and/or grind your teeth in your sleep?

Do you have a balanced diet? *(e.g. how much processed food do you eat per week, how much fruit and vegetables)*

How much do you drink daily?

Water:

Tea: Coffee:

Other:

Alcohol: *(per week)*

Do you smoke? No Yes

If yes, amount per day:

Do you have any dietary problems? *(e.g. overeating, intolerances, bingeing)*

Any other relevant information:

I herewith declare that all of the information given is true to the best of my knowledge, and that if any of the above circumstances were to change I would inform you at my next treatment. I confirm that I have understood the treatment that I am to receive and confirm that I am willing to proceed without confirmation from my own GP or Consultant.

Signed: …….....…… Date: ……

The Bowen Technique is not intended as a substitute for medical advice or treatment.
If in doubt please consult your Doctor.