BOWEN
PAIN CLINIC

Health History Form Date:_____

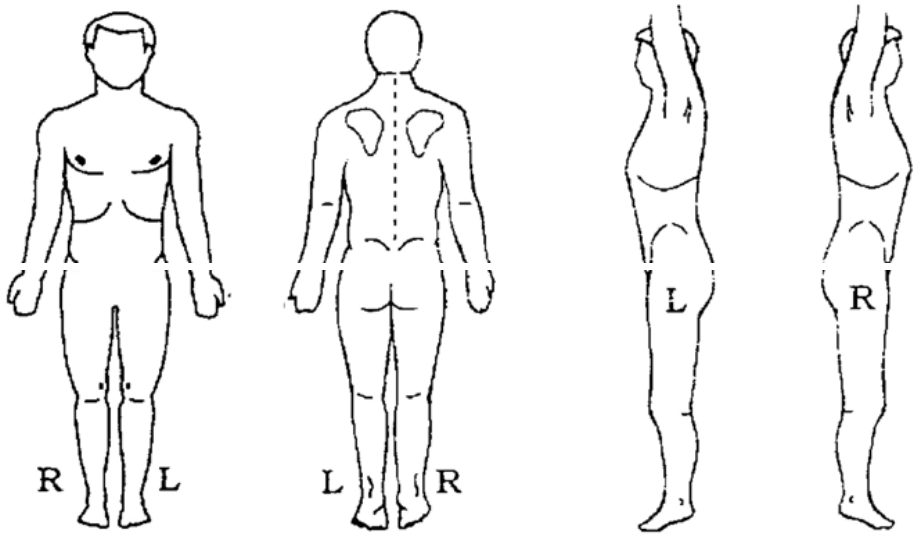
General Information					
First / Last Name					
Email					
Phone Preferred		Phone Other			
Street					
City		Prov or State		Postal	
Date of Birth		Referred by			
Emergency Contact Name and Number:					
How did you hear of us?					
Any recent bodywork? Date:		Describe:			

Physician	
Physicians Name	
Physicians Phone Number	
Permission to contact your doctor?	☐ Yes ☐ No

Reason for Appointment	
Primary complaint	
Pain location and Intensity (1 - 10)	Intensity _____
When does your pain increase?	
When does your pain decrease?	

Please indicate with an X the location of your pain or condition

Pain patterns/restricted movements:



Other comments

Medical	
Date	**Please list surgeries, hospitalizations, previous injuries, tests, x-rays etc**
Please identify any metal implants, internal pins, wires, artificial joints or special equipment that you may have:	

Lifestyle		
Please describe your current exercise routine		
Do you smoke? How much? How long?		
Do you wear orthotics? Describe:		
Daily consumption:	Water	
	Tea	
	Coffee	
	Soft drinks	
	Alcohol	

Health Conditions	Y	N	Describe
Bronchitis/asthma/shortness of breath or chronic cough			
Poor circulation/bruise easily			
Loss of sensation in hands or feet			
Liver/gallbladder/poor digestion			
Insomnia			
Hiatus hernia			
Constipation/diarrhea - please indicate number of BM's per day or per week			BMs per day: _____ or week: _____
Numbness/tingling			
Diabetes			Type: Date of onset:
Allergies			
Hayfever			
Epilepsy			
Cancer			
Arthritis			
Vision Problems			
Ear infections / poor hearing / tinnitus			
Bladder / Kidney			Voids per night _____
Joint or soft tissue pain			
High or low blood pressure			
Heart attack			
Congestive heart failure, disease, stroke			
Phlebitis			
Pacemaker			
Headaches			

Health Conditions	Y	N	Describe
Hepatitis			
Skin rashes / infectious skin conditions			
Fibromyalgia			
Mononucleosis			
Back pain			
Varicose veins			
Psychological issues / trauma			
Other			

Women's Health	Y	N	Describe
Are you pregnant?			Due date:
Are trying to conceive?			
Last menstrual period			Date:
PMS, fibroids/difficult menstruation			

I, (print)_____ understand the treatment goals, risks and benefits as explained by the nurse and I give consent to treatment. I have had an opportunity to ask questions about the treatment. I understand that Janet Riley does not treat, prescribe or diagnose any illness, disease, or other physical or mental disorder and that any information concerning health status relayed to Janet Riley has also been given to my physician. I also certify that no guarantee has been made as to the results that may be obtained.

I hereby give Janet Riley permission to collect personal information, including personal health information from me. I understand I may request access to my personal information at any time. Upon completion of my treatment program, any request for Janet Riley to share/release client specific information acquired through the episode of care will require a specific informed consent from the client for release of specifically requested information.

Signature _____ Date _____