Confidential Consultation Form

Name:_____ Date of birth:_____

Address:_____ Postcode:_____

Telephone no:_____Work:_____Mobile:_____

Occupation:_____ Email:_____

How did you hear about me/Bowen?_____

Marital Status: Single/Married/Living with partner/Separated/Divorced/other (please circle)

Do you have any children? Yes/No If so, how many?_____ What age range?_____

GP name & Address:_____

How often do you go?_____When was your last consultation?_____

Please list any medication you are currently using: _____

Please briefly describe the health problem(s) you would like help with:_____

_____

On a scale of 1-10 what is you pain level?_____

When did your problem start?_____

What other forms of therapy have you received regarding this condition?_____

Please list if you have ever had any of the following:

Operations_____

Accidents_____

Illnesses_____

How does this effect you now?_____

Do you use orthotic appliance in your shoes? _____

Do you experience ringing in the ears, clicking/popping of the jaw or facial pain? _____

Have you had your wisdom teeth removed? Yes/No If so, was it all at once? Yes/No

Have you had any other teeth removed? Yes/No If so, was it for overcrowding? Yes/No

Were you fed as a baby by breast/bottle (plse circle)

Is there any possibility you are or could be pregnant? Yes/No If yes, how advanced?_____

How many pregnancies have you had? _____ Were there any complications? _____

Menstrual cycle: regular □ irregular □ painful □ heavy □ menopausal □ other □

Do you have breast or other implants? _____

Do you smoke? Yes/No If yes, how many a day? _____ for how long?_____

How many units of alcohol do you consume in a week?_____
(1 pint beer = 2 units, 1 glass of wine or pub measure spirit = 1 unit)

How many cups of tea or coffee, per day?_____

How many glasses of pure water do you drink a day?_____

Other fluid intake:_____

Please list any supplements you are currently taking _____

_____

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Please describe your usual diet: Breakfast_____

Lunch_____Dinner_____

How many portions of fruit & vegetables do you consume a day?_____

What do you snack on?_____

Do you cook yourself? _____Do you buy ready meals/processed foods?_____

Do you sleep well? Yes/No If not, why not?_____

Do you suffer with fatigue/tiredness? _____

On a scale of 1-10 what is your daily energy level_____

Do you suffer with digestive upsets? _____

Are your bowel movements: daily □ less than daily □

How often do you exercise? daily □ weekly □ occasionally □ never □

What do you do to switch off or relax?_____

Please list any other concerns/comments regarding your symptoms/state of well-being, even if you feel they have no relevance to your current condition.

_____

_____

_____

_____

I confirm the information given is correct to my knowledge, and if any of the above circumstances were to change I would inform you at my next appointment. I give my consent to receive The Bowen Technique Therapy without consent from my own GP or consultant.

Signed…….. Date: ……..…..

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The Bowen Technique is not intended as a substitute for medical advice or treatment.