NATUROPATHIC PERSPECTIVES

Redefining Your Health

Bowen Supplemental Form

CLIENT RECORD CONFIDENTIAL WHEN COMPLETE

Describe your work conditions *(eg. standing a lot, sitting for long periods, repetitive movements).*

What major injuries have you had?	When?	Long term effects?

What operations/major dental work have you had?	When?	Complications?

	Allergies/Hay Fever		Cancer		Dizziness		Heart Condition		Meniere's Disease		Scoliosis
	Angina		Carpal Tunnel Syndrome		Ear Problems		Hernia (Inguinal)		Edema		Shin Splints
	Ankle Problems		Chest Pain		Eczema		Hiatal Hernia		Osteoporosis		Sinus Problems
	Arthritis		Coccyx Pain		Emphysema		Immune System		Pelvis/Hip Problems		Sprung Ribs
	Asthma		Constipation		Eye/Vision Problems		Incontinence		Period Cramps		Sterility
	Back Ache/Pain		Diabetes		Fluid Retention		Infertility		Plantar Fasciitis		Sternal Pain
	Bell's Palsy		Diaphragm Pain		Frozen Shoulder		Jaw/TMJ Problems		Pre-menstrual Tension		Teeth/Gum Problems
	Bladder Problems		Diarrhea		Gall Bladder		Kidney/Bladder		Prostrate Problems		Tennis Elbow
	H/L Blood Pressure		Digestive Problems		Groin Strain		Leg Cramps		Psoriasis		Thrush
	Breast Lumps/Pain		Deafness		Hemorrhoids		Liver Problems		Respiratory Problems		Thyroid Problems
	Bronchitis		Depression		Hammer Toes		Lumbago		Sacral Pain		Tonsillitis
	Bunions		Disc Problems		Headache/ Migraine		Lymph Problems		Sciatica		Varicose Veins

Notes: _____

Naturopathic Perspectives
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Women

Date of last menstrual period? _____ Are you pregnant? _____ Any menopausal symptoms? _____

Physical Assessment (to be completed by practitioner)

Shoulder Height	*Higher on Left/Right Even*	Hips/Pelvis		Spine Curvature	
Lateral Stretch		Touch Toes		Bend Back	
	North South East				
Neck/Shoulders	*West*	Flexibility		TMJ/Bite	
Hamstrings		FABER Test	*Pelvic (L/R)*	*Sacrum (L/R)*	*Coccyx (L/R)*
Leg Length	*Left/Right shorter*	Kidney			

Physician's Name _____ Other Practitioners _____

Phone Number _____

Client's Statement of Accountability

I understand that The Bowen Technique is not a substitute for accredited medical attention. I agree to undertake Bowen treatments as a method of supplementing my overall health and well-being regime, and take full responsibility for my own care. The use of other modalities in conjunction with Bowen and the aftercare protocol has been explained to me and I understand this information.
I will communicate any marked changes in my health to my primary health practitioner. In the case of a blood pressure problem, I will seek out any necessary adjustments to my medication as a result of receiving Bowen treatments. I will not discontinue any prescribed medication without the full knowledge and agreement of my physician.

_____ _____

Signature Date