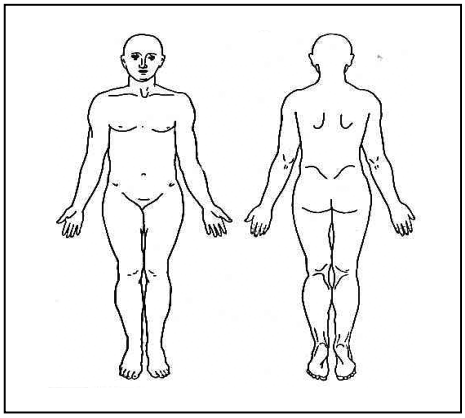
Siân Rackham, CBT
Certified Bowen Therapist
srackham@bewellnow.ca

Bowen Therapy Consultation

Confidential Patient Information

Name:	**Age:**	**Date of Birth:**
Address:	**City:**	**Postal Code:**
Home Tel:	**Work Tel:**	
E-mail:		
I give permission to be emailed occasionally of specials or new treatments: Yes or No (circle)		
Number of Children:	**Ages:**	
Occupation:		**How Long:**
Referred by:		
Present M.D. and phone #:		

Please indicate injury site and areas of pain.



Chief complaints in order of importance for you?	**Since?**	**Causes?**	**Severity on a scale of 1-10 (with 10 indicating severe)**

What aggravates your pain?

Are you experiencing any swelling? Where?

_____

_____

What medications are you currently taking?	Since?	Any adverse effects?

Are you currently under the care of any other physicians or health care practitioners?

Who:	**For:**	**Treatment:**
Who:	**For:**	**Treatment:**

What treatments or therapies are you currently taking?	Since?	Results?

Do you have a pacemaker or any implants including orthotics?

_____

Any other major injuries or conditions?	Since?	Complications or long-term effects?

What operations have you had?	When?	Complications?

What exercise(s) do you do, how much, and how often?

_____

_____

_____

Have you been treated with Bowen before?

_____

Is there anything you would like to add?

_____

_____

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Bowen Therapy Informed Consent:

Bowen Therapy is a form of bodywork that addresses the body as a whole. A series of gentle moves are applied to the body, a pause is given between the moves, and the body begins to absorb the signal and facilitate a healing response. Generally a session lasts an hour long. Bowen Therapy stimulates the nervous system, encourages a state of relaxation, and assists the body in resetting and rebalancing. As structure governs function, not only musculoskeletal problems are addressed but imbalances with internal organ systems as well. Bowen can be used from newborn babies to the frail and elderly, used often in the most sensitive of cases.

All visits are confidential. A record will be kept of all the procedures used along with case study notes. This record will be kept confidential and will not be released to others unless so directed by you or if the law requires it.

If required, your case may be discussed with other health care providers to assist you in your treatment plan.
I give permission for my case and treatment plan to be discussed with other healthcare practitioners to collaborate on my case. _____ (Initial)

I, the undersigned, do hereby acknowledge that I have been informed of and understand what Bowen Therapy is and what it does, and I understand the therapeutic procedures to be used for and on me to my satisfaction.
As a result, I do hereby voluntarily consent to receive Bowen Therapy.

Signature: _____ Date: _____
Printed Name: _____

Bowen Practitioner: _____