Client Intake Form

BOWEN CENTRAL
BRINGING BACK BALANCE

Name: **Date:**

Address: **DOB:**

Email: **Mobile:**

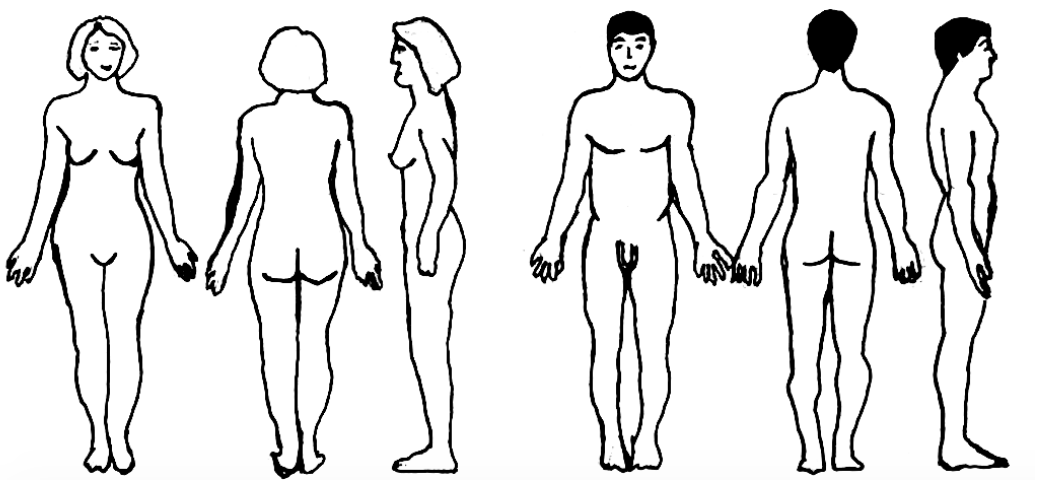
Occupation:

Emergency Contact:

Reason for Visit:

Client Goals for Treatment:

Circle Areas of Pain or Discomfort:



Surgery/Accidents/Injuries/Illnesses (Years & Description):

_____

_____

_____

Medication/Supplements:

_____

_____

Other Healthcare Practitioners Name & Phone Number:

_____

_____

Email Newsletter Subscription:

☐ *Tick to receive Educational Health & Wellness Content*

Please put a tick beside any of the following conditions that you currently have or have had in the past:

Nervous:
- ❑ Headaches
- ❑ Pain / Numbness / Tingling
- ❑ Dizziness
- ❑ Sleeping problems
- ❑ Epilepsy
- ❑ Vision Problems
- ❑ Depression

Respiratory:
- ❑ Asthma
- ❑ Breathing Difficulty
- ❑ Sinus / Sinusitis

Skin:
- ❑ Fungal Condition
- ❑ Eczema / Rash

General:
- ❑ Stress
- ❑ Cancer
- ❑ Dental

Reproductive:
- ❑ Pregnant
- ❑ PMT / Menopause
- ❑ Prostate

Muscular:
- ❑ Pain
- ❑ RSI / OOS
- ❑ Bruising Easily
- ❑ Carpal Tunnel Syndrome

Skeletal:
- ❑ Arthritis / Gout
- ❑ Osteoarthritis
- ❑ Joint Replacement

Digestive:
- ❑ Discomfort / gas
- ❑ Diabetes
- ❑ Allergies
- ❑ Constipation / Diarrhea
- ❑ Irritable Bowel Syndrome

Cardiovascular:
- ❑ Heart problems / Chest pain
- ❑ High or Low blood pressure
- ❑ Blood Clots
- ❑ Poor Circulation / cold extremities
- ❑ Oedema / Inflammation
- ❑ Varicose Veins

Immune:
- ❑ Fibromyalgia
- ❑ Colds /Flus
- ❑ Chronic Fatigue Syndrome / ME
- ❑ Allergies
- ❑ Hepatitis A/B or C