BOWEN by the Bay – Concord • Rhodes • Homebush Bay • Abbotsford

Client Information Sheet

All information is STRICTLY CONFIDENTIAL

Name: ..... Date of Birth: .....

Address: .....

.....

Email: ..... Phone: .....

Occupation: ..... Years: .....

Emergency Contact: ..... Phone: .....

Sports/Hobbies/Recreation:

What is the reason for your visit?

Who referred you / How did you hear about me?

Please tick if you have problems with any of the following:

☐ Sports injury	☐ Frozen Shoulder	☐ Lower back	☐ Hamstring
☐ Fertility	☐ Scoliosis	☐ Joints	☐ Breasts
☐ Sciatica	☐ Tennis elbow	☐ Constipation	☐ Coccyx (tailbone)
☐ Diabetes	☐ Headache/migraine	☐ Jaw tension	☐ Whiplash
☐ Chronic Fatigue	☐ Hormonal	☐ Bladder	☐ Prostate
☐ RSI	☐ Lungs	☐ Asthma	☐ Blood pressure – (H/L)
☐ Heart	☐ Eyes/Ears	☐ Stiff neck	☐ Liver
☐ Gall Bladder	☐ Dental	☐ Ankle/feet	☐ Knees
☐ Digestion	☐ Sinus/Allergies	☐ Kidney	☐ Hips
☐ Other			

How do you regard your health problem(s)? (Please tick) ☐ Severe ☐ Moderate ☐ Mild

What other forms of therapy have you used?

Please list previous/other Diagnosis, Illness, Accidents, Broken Bones, Injuries, Surgeries & Falls that you have had:

Please list any medication/supplements (Vitamins/minerals etc) you are currently taking:

Do you have any children, if so, how many and what ages?

What is your daily intake of water? - Do not include fruit juice/herbal tea/coffee (Please tick)

☐ 2 litres ☐ 1 Litre ☐ 500ml ☐ Less

How is your diet/Lifestyle? (Please tick) ☐ Good ☐ Average ☐ Poor

What are your favourite foods?

How often do you exercise? (Please tick) ☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

On a scale of 1-10 what is your energy level? (1 being Low; 10 being High)

Do you sleep well? If no, why do you think this is?

Do you smoke cigarettes? (Please tick) ☐ Yes ☐ No Qty/day:

Do you have any implants/pacemaker/other?

Do you use orthotic appliances/build ups in your shoes?

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

Did you ever have jaw surgery?

Have you had dental reconstruction/implants?

Have you had your wisdom teeth removed? If so, was it all at once?

Have you had any other teeth removed? If so, was this for overcrowding?

Did you ever wear orthodontic appliances/brace?

For the Ladies

Do you have breast implants? (Please tick) ☐ Yes ☐ No	Is there any chance you are pregnant? ☐ Yes ☐ No
Menstrual Cycle: (Please tick) ☐ Regular ☐ Irregular ☐ Painful ☐ Heavy ☐ Menopausal ☐ Post-menopausal	

Please read before signing

By signing this form, the client indicates the willingness to accept any results of the treatment conducted by this care/practitioner without holding the practitioner or the Centre liable for any circumstance, condition or aggravation that the treatment may have caused.

Signature: _____ Date: .....

(must be signed by a parent or guardian if under the age of 16)