EMPOWERED HEALING HUB

Client Information

Full Name _____ Date _____

Address _____ Contact Phone _____

Email Address _____

Occupation _____ Physical Activity Level: Circle **High, Med** or **Low**

Address _____

Emergency Contact Name & Contact Phone _____

Is this your first Bowen Treatment ? **Yes** **No**

Have you worked with Emma before? **Yes** **No**

How can we support you?

What health challenges bring you into the office today?

_____

_____

What are your goals for today's visit?

_____

_____

What therapies/healing modalities are you currently using?

_____

_____

What therapies have you utilized in the past and how long ago?

_____

_____

Have you ever suffered any recent injuries or trauma, been hospitalized, or had surgery? If yes, briefly describe:

_____

_____

Have you ever fallen and/or injured your tailbone? If yes, please describe:

_____

_____

Are you presently under a medical practitioner's care? If yes, briefly describe relevant care plan(s) or the reason(s) for any significant appointment(s):

_____

_____

_____

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Client Health Record

Please mark any conditions below if you have experienced or are currently experiencing them;

Allergies ☐	Cancer ☐	Pregnancy ☐
Diabetes ☐	High Blood Pressure ☐	Breast feeding ☐
Skin Irritation ☐	Low Blood Pressure ☐	Eye Issues ☐
Heart Problems ☐	Blood Clots/Circulation ☐	Hypermobility ☐
Varicose Veins ☐	Breathing Issues ☐	IBS/Gut Issues ☐

If yes, please explain how it is being managed/treated and what medications, if any, are being utilized;

_____

_____

If yes, how long have you experienced these conditions and to what degree of impact are they?

_____

_____

_____

_____

- Are you taking any vitamins, supplements or herbal remedies? **Yes** **No**

  if yes, please specify _____

  _____

- Do you have any sensitivities or special needs that the Practitioner should be aware of to ensure your comfort? **Yes** **No**

  if yes, please specify _____

  _____

- Do you experience prolonged stress, PTSD or other mental health symptoms that impact your nervous system? **Yes** **No**

  if yes, please specify _____

  _____

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Client Health Check

Circle the places of pain on the drawing below and rate the severity of each pain on scale of 1-10.

Pain intensity scale

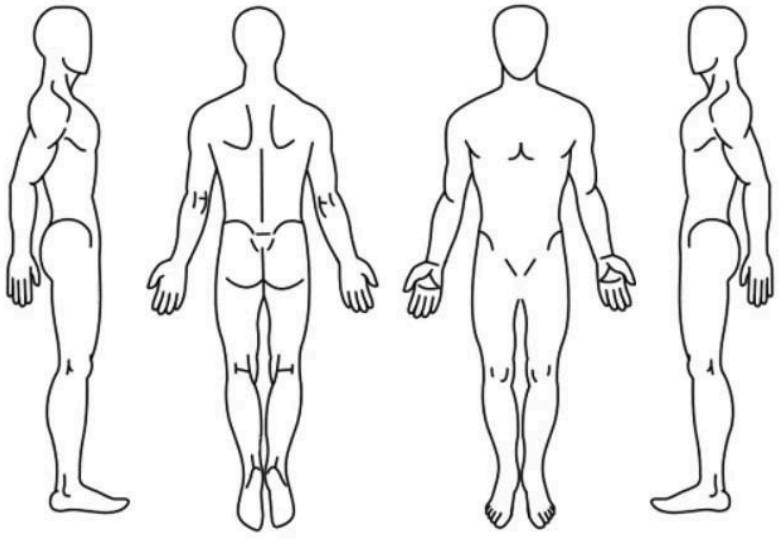
1-2: Mild
(annoying, nagging)

3-4: Discomfort
(troublesome, numbing)

5-6: Distressing
(miserable, agonizing)

7-8: Intense
(cramping, dreadful, horrible)

9-10: Excruciating
(tearing, unbearable)



Right Back Front Left

Please circle the number that best corresponds to how you feel:

PHYSICAL

1 2 3 4 5 6 7 8 9 10

Little to no exercise, poor diet, poor sleep, I'm in pain

Very little pain, Exercise daily, meditate, excellent diet, great sleeper

MENTAL

1 2 3 4 5 6 7 8 9 10

I'm a worrier and my brain is always working

I can let go of stress and turn my brain off easily

EMOTIONAL

1 2 3 4 5 6 7 8 9 10

I hold my feelings in and feel sad inside often, don't feel supported

I feel fully expressed, supported, and joyful in my heart

SPIRITUAL

1 2 3 4 5 6 7 8 9 10

I'm not living my life purpose, I feel stuck

I am living a purposeful and meaningful life

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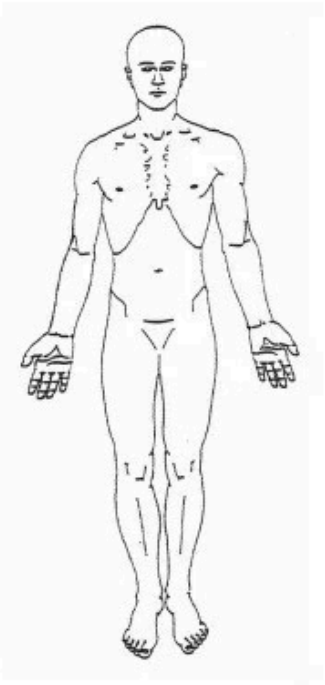
Session Notes

Client Name _____ **Date** _____



Subjective Symptoms: Onset / Location / Intensity / Frequency / Aggravating Factors

_____

_____

_____

_____

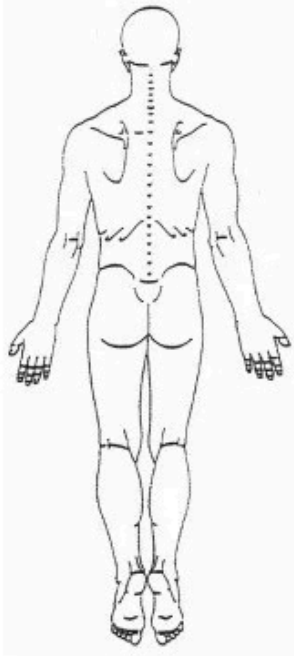
Objective Findings: Visual / Palpable / Test Results

_____

_____

_____

_____



Assessment Goals: Long Term / Short Term

_____

_____

_____

_____

Plan: Future Treatment / Frequency / Self-Care

_____

_____

_____

_____

Signature _____