

# HANDS-ON THERAPY (Bowen and Massage)

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**MEDICAL HISTORY** *Please fill in where relevant*

Reason for visit: \_\_\_\_\_

Past major illnesses, injuries or medical treatments: \_\_\_\_\_

Any previous therapy you have had in the past: \_\_\_\_\_

Current medication: \_\_\_\_\_

Forms of exercise you are currently involved in? \_\_\_\_\_

*Please tick if you have any of the following symptoms/conditions:*

- |   |   |
|---|---|
| <input type="checkbox"/> Sporting injuries              | <input type="checkbox"/> Breathing problems (asthma, sinuses) |
| <input type="checkbox"/> Headaches                      | <input type="checkbox"/> Allergies                            |
| <input type="checkbox"/> Migraines                      | <input type="checkbox"/> Eczema                               |
| <input type="checkbox"/> Orthodontic treatment          | <input type="checkbox"/> Arthritis                            |
| <input type="checkbox"/> Jaw pain                       | <input type="checkbox"/> Infertility                          |
| <input type="checkbox"/> Whiplash                       | <input type="checkbox"/> Are you having trouble conceiving?   |
| <input type="checkbox"/> Stiff neck                     | <input type="checkbox"/> Are you pregnant?                    |
| <input type="checkbox"/> Scoliosis                      | <input type="checkbox"/> Implants (Hormonal or Breast)        |
| <input type="checkbox"/> Lower back pain                | <input type="checkbox"/> Breast lumps                         |
| <input type="checkbox"/> Coccyx pain                    | <input type="checkbox"/> Indigestion                          |
| <input type="checkbox"/> Hip/Pelvic pain                | <input type="checkbox"/> Colic and night crying (for babies)  |
| <input type="checkbox"/> Sciatica                       | <input type="checkbox"/> Bedwetting (Children)                |
| <input type="checkbox"/> Hamstrings                     | <input type="checkbox"/> Growing pains (Children)             |
| <input type="checkbox"/> Knee pain                      | <input type="checkbox"/> Overweight                           |
| <input type="checkbox"/> Ankle/Feet                     | <input type="checkbox"/> ADD/ADHD                             |
| <input type="checkbox"/> Frozen shoulder                | <input type="checkbox"/> Stress                               |
| <input type="checkbox"/> Tennis elbow                   | <input type="checkbox"/> Depression, Anxiety, Phobia          |
| <input type="checkbox"/> RSI (Repetitive Strain Injury) | <input type="checkbox"/> Cancer                               |
| <input type="checkbox"/> Aches/pains                    | <input type="checkbox"/> Skin disorders                       |
| <input type="checkbox"/> Heart conditions               | <input type="checkbox"/> Dizziness                            |
| <input type="checkbox"/> Spinal injury                  | <input type="checkbox"/> Numbness                             |
| <input type="checkbox"/> Osteoporosis                   | <input type="checkbox"/> Joint replacements                   |
| <input type="checkbox"/> Joint pain/swelling            | <input type="checkbox"/> Recent fractures                     |
| <input type="checkbox"/> Thrombosis/inflammation        | <input type="checkbox"/> Varicose veins                       |