Best of Health Massage Therapy

Client Information & Bowen Therapy Waiver

Client Name: _____ Birthdate: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Home Phone : _____ Cell Phone: _____

Email: _____

Occupation: _____

Referred by: _____

Goal(s) for this treatment: _____

For Clients Under 18:

Guardian Name: _____ Relationship: _____

Phone Number: _____

Email: _____

Bowen Therapy Waiver:

By signing this form, I indicate a willingness to accept any result of the treatment conducted or recommended by this therapist, without holding the clinic or therapist liable for any circumstance, condition or aggravation of thereof treatment may influence or cause. This treatment does not in any way replace medical treatment where necessary.

Cancellation Policy:

Please note that 24 hours' notice is required to re-schedule or cancel appointments. If less than 24 hours' notice is given, or an appointment is missed, a **$50 fee** will be applied. To change an appointment, please call 587.775.1514 or use the online booking calendar at www.bohm.ca

Client Name: _____

Client/Guardian Signature: _____

Date: _____

Best of Health Massage Therapy - Confidential Client Medical History

This history is strictly confidential and will not be released to anyone without your prior written consent. The information gathered will help determine the appropriate type of procedures to be included in your treatment plan.

NAME: _____ DATE: _____

Please indicate which conditions you currently suffer from or have suffered from in the past:

- ☐ Anxiety
- ☐ PTSD
- ☐ ADHD
- ☐ Seizures
- ☐ Autism
- ☐ Heart Disease *List type:* _____
- ☐ Insomnia
- ☐ Stroke
- ☐ Epilepsy
- ☐ Depression
- ☐ Panic Attacks
- ☐ Atrial Fibrillation
- ☐ Cerebral Palsy
- ☐ Fibromyalgia
- ☐ Adrenal Fatigue
- ☐ Heart Attack
- ☐ Cancer *List Location(s):* _____
- ☐ Chronic Fatigue Syndrome
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Scoliosis/Lordosis/Kyphosis
- ☐ Stressed/Overwhelmed

- ☐ Varicose Veins
- ☐ Sciatica
- ☐ Diabetes
- ☐ Ulcers
- ☐ Endometriosis
- ☐ Hamstring Pain
- ☐ Knee Pain
- ☐ Ankle Pain
- ☐ Heel Pain
- ☐ Plantar Fasciitis
- ☐ Prostate Problems
- ☐ Hemorrhoids
- ☐ Drop Foot
- ☐ Constipation
- ☐ Chronic Diarrhea
- ☐ Slipped/Herniated/Bulging Disc
- ☐ Degenerative Disc Disease
- ☐ Abnormal Gait (walk)
- ☐ Incontinence/Bladder Issues
- ☐ Gynecological Problems

- ☐ Dementia
- ☐ Alzheimer's
- ☐ Confusion
- ☐ Mucus Cough
- ☐ Vertigo
- ☐ Sinus Issues
- ☐ Tennis Elbow
- ☐ Carpal Tunnel
- ☐ Stiff Neck
- ☐ Dizziness
- ☐ Earaches
- ☐ TMJ/ Jaw Pain
- ☐ Low Back Pain
- ☐ Whiplash
- ☐ Migraines
- ☐ Frequent Colds
- ☐ Dry/Runny/Itchy Eyes
- ☐ Impaired Vision
- ☐ Kinked Neck
- ☐ Sternal Pain
- ☐ Postural Issues
- ☐ Difficulty Swallowing Food
- ☐ Frozen Shoulder or Injury
- ☐ Grind/Clench Teeth
- ☐ Tension Headaches
- ☐ Rib Pain or Injury
- ☐ Concussion *Date(s):* _____
- ☐ Tailbone Pain or Injury

- ☐ Skin Allergies
- ☐ Emphysema
- ☐ Diverticulitis
- ☐ Edema
- ☐ Asthma
- ☐ Allergies
- ☐ Indigestion
- ☐ Heartburn
- ☐ Gas
- ☐ Bloating
- ☐ Colitis
- ☐ IBS
- ☐ Respiratory Issues
- ☐ Crohn's Disease
- ☐ Multiple Sclerosis

- ☐ Osteoporosis
- ☐ Neuropathy
- ☐ Lupus
- ☐ Parkinson's Disease
- ☐ Muscular Dystrophy
- ☐ Rheumatoid or Osteo Arthritis

Women Only:

Are you Pregnant?

- ☐ Yes
- ☐ No

For any of the following that are applicable, please list location(s) and/or type:

- ☐ Implants _____
- ☐ Fusions _____
- ☐ Sprains _____
- ☐ Broken Bones _____
- ☐ Contagious Conditions _____
- ☐ Tendinitis _____
- ☐ Blood Clots _____
- ☐ Limited Range of Motion _____

1134 Coopers Drive SW, Airdrie AB T4B 0Z8
Phone (587)775-1514 Email Theresa@bohm.ca
www.BOHM.ca

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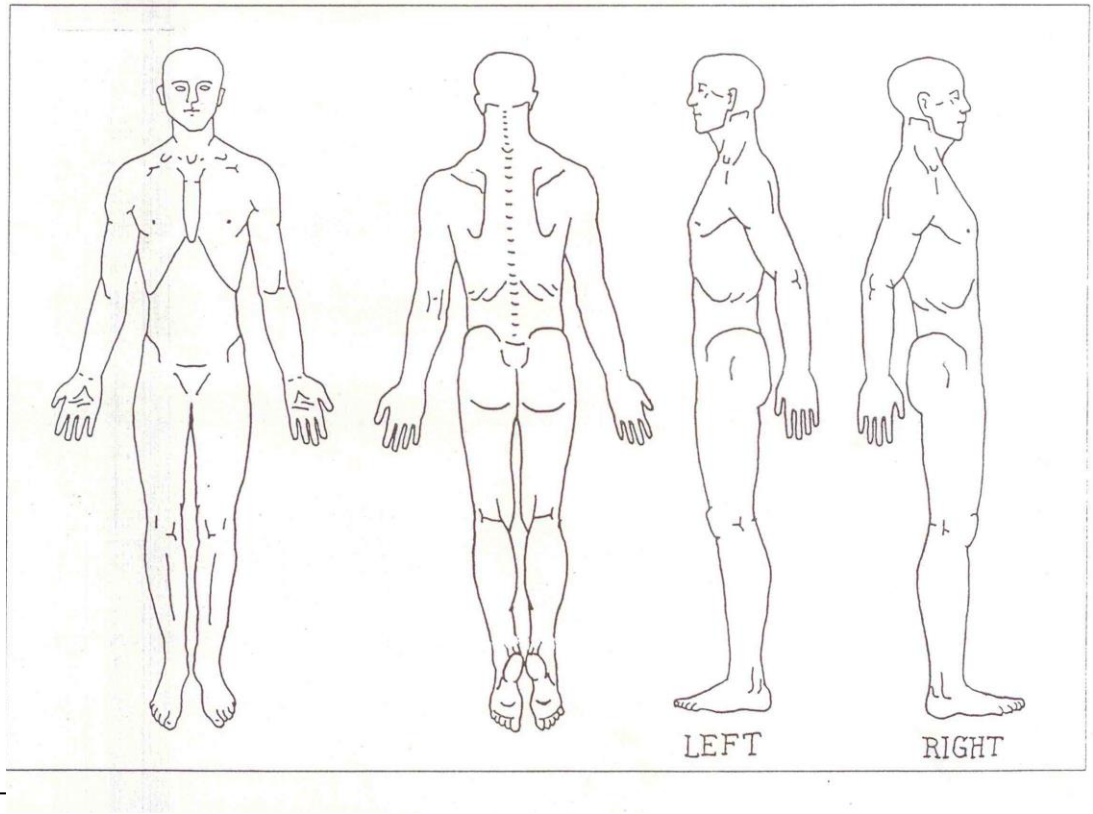
NAME: _____ DATE: _____

Please make an X or circle over areas where you experience pain or discomfort.



Please list any other relevant conditions or concerns:

_____

_____

_____

_____

_____

_____

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Session 1 - Date:

Your assessments:

Procedures used:

Post Treatment Comments/observations:

Session 2 - Date:

Client's comments: progress/changes observed since last session:

Procedures used:

Post Treatment Comments/observations:

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Session 3 - Date:
Client's comments: progress/changes observed since last session:

Procedures used:

Post Treatment Comments/observations:

Session 4 - Date:
Client's comments: progress/changes observed since last session:

Procedures used:

Post Treatment Comments/observations:

Session 5 - Date:
Client's comments: progress/changes observed since last session:

Procedures used:

Post Treatment Comments/observations:

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