

# Bowenwork® Northwest

707 Pine Ave., Ste A102  
Snohomish, WA 98290

360.568.7075  
fax: 360.568.3205

Please fill out both sides

## Personal Data

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

Address: \_\_\_\_\_

City / State / Zip: \_\_\_\_\_

Phone-Home: \_\_\_\_\_ Phone - Cell: \_\_\_\_\_

Birthdate: \_\_\_\_\_

E-mail: \_\_\_\_\_

Preferred method of contact? Phone \_\_\_\_\_ E-mail: \_\_\_\_\_

Occupation / Employer: \_\_\_\_\_

Primary Physician: \_\_\_\_\_

Primary Physician Phone: \_\_\_\_\_

Permission to consult with primary physician? Yes \_\_\_\_ No \_\_\_\_  
(If yes please initial) \_\_\_\_\_

Emergency contact: \_\_\_\_\_

Phone: \_\_\_\_\_

What are your areas of concern?

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## Injury information:

Date of injury or accident: \_\_\_\_\_

PIP / L&I: \_\_\_\_\_ Claim #: \_\_\_\_\_

Please review the PIP questionnaire

Previous History (include year and treatment received)

Surgeries:

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Accidents (including car accidents, falls, sports injuries, etc):

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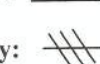
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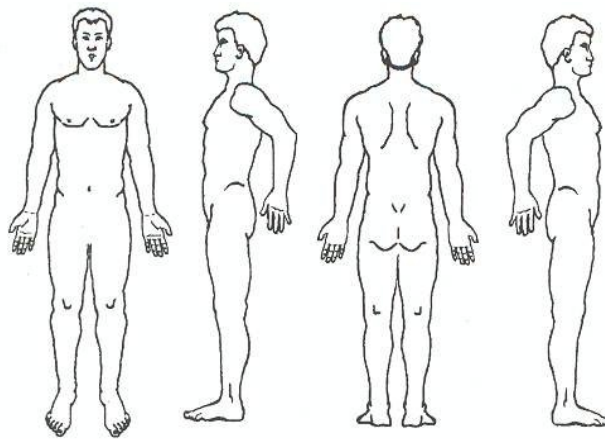
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Habits (Please Circle)

Water	8+ cups	5 cups	2 cups	
Nutrition	Excellent	Good	Fair	Poor
Alcohol	Heavy	Moderate	Light	None
Coffee	Heavy	Moderate	Light	None
Tea	Heavy	Moderate	Light	None
Tobacco	Heavy	Moderate	Light	None

Mark diagram for areas of:

- Pain: 
- Spasm: 
- Tension: 
- Surgery: 
- Injuries: XXX



**Pain Scale**

- 0 = No pain
- 1 = Slight pain
- 2
- 3 = Mild pain
- 4
- 5 = Moderate pain
- 6
- 7 = Severe pain
- 8
- 9 = Very severe pain
- 10 = Worst possible pain

MEDICAL RELEASE: It is my choice to receive a bodywork therapy. I realize that the treatment is being given for the well being of my body and mind. This includes stress reduction, relief from muscular tension, spasm or pain, or increasing circulation and energy flow. I understand that bodywork practitioners do not diagnose illness, disease, or any physical or mental disorder, nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations. I acknowledge that bodywork is not a substitute for medical examination or diagnosis and that it is recommended that I see a primary health care provider for that service. I have stated all medical conditions I am aware of and will communicate with the practitioner regarding any changes in the status of my health or well being.

RELEASE OF BENEFITS AND INFORMATION: I authorize my insurance benefits to be paid directly to Bowenwork Northwest, a div. of Massage & Bowen Northwest, Inc. I understand that I am financially responsible for any balance due. I authorize Bowenwork® Northwest, a div. of Massage & Bowen Northwest, Inc. to release any information required for any insurance claim.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature of Parent or Guardian (if under the age of 18)

\_\_\_\_\_ Date \_\_\_\_\_