TRI-CITY
WELLNESS CENTRE
BOWEN THERAPY

New Patient Intake Form

Please fill out the following:

First Name: _____ Last Name: _____

Address: _____ City: _____

Postal Code: _____ Phone #: _____

Email: _____ Occupation: _____

Date of Birth: _____ Male ☐ Female ☐

Let me learn a little about yourself with the following questions:

List sports, hobbies, activities you participate in and how often you do it (daily, weekly, monthly): _____

_____

_____

_____

Any previous operations, accidents and or illnesses. Also include dates and details on these occurrences: _____

_____

_____

_____

What are you seeking treatment for? Present condition(s): _____

_____

_____

_____

Are you taking any medications, vitamins, and/or supplements? Please list: _____

_____

_____

_____

Prior treatment for present condition(s). Check all that apply.

*Please note that, because of the subtlety of Bowenwork and the body's continuing response to it, other forms of manipulative therapy performed up to four days before, or five days after a Bowen session may interfere with its effectiveness.

_____	Chiropractic Adjustment	_____	Surgery
_____	Massage	_____	Cranial Sacral Therapy
_____	Osteopathy	_____	Facial Massage
_____	Physiotherapy	_____	Regimen (Diet, Exercise Plan, etc.)
_____	Reiki	_____	Hydrotherapy
_____	Homeopathy	_____	Hypnotherapy
_____	Herbs	_____	Prescription Medication
_____	Other	_____	None of the Above

Any other relevant information you would like to share about your past/present physical or mental condition(s): _____

_____

_____

_____

How did you hear about Tri-City Wellness Centre and/or Georgina Hanchar? _____

_____

_____

_____

Statement of Acknowledgement
Each patient seeking care from this office should understand that the Bowen Therapist is certified and specializes in Bowen Therapy and is not a Medical Doctor. If standard medical diagnosis or treatment is required, it must be obtained from a licensed medical doctor.

Patient Consent Form
Privacy of your personal information is an important part of our clinic, while providing you with quality care. We understand the importance of protecting your personal information. This clinic will collect, use and disclose information about you for the following purposes: to assess your health concerns, to advise you of treatment options, to establish and maintain contact with you, to send you a newsletter and other information mailings, to remind you of upcoming appointments, and to complete claims for insurance purposes.

I have read and understood the above consent for myself and/or my child.

Signature: _____ Date: _____

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