JIHAN adem

MANUAL THERAPIST
BOWEN THERAPY INSTRUCTOR
TMJ AND BREATHING SPECIALIST

# Confidential Client Record Sheet

## Bowen Therapy Treatment

First Name _____Surname _____

Tel no (Home)_____ Mobile)_____

Email address _____

Address_____

_____

D.O.B _____ Occupation _____

How did you find out about me/this treatment?

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G.P. Name_____ Tel no_____

Address_____

_____

Condition Requiring Treatment_____

Have you had a Doctor's Diagnosis

_____

Doctors treatment _____

Are you taking any medication for any health complaint? Yes / No

If Yes please list_____

Have you ever had an x-ray? Yes / No

Please list past surgeries_____

Which past illnesses have you had? _____

Is there a history of any of the following conditions in your immediate family? High/Low BP Yes/No

Diabetes Yes / No Heart Yes / No Lung Yes / No Cancer Yes / No Epilepsy Yes/No

Other _____

Have you any of the following symptoms?

Headaches Yes / No Fainting Yes / No Allergies Yes / No Please list_____

Sinus Yes / No Chills Yes / No Fever / Hot Flushes Yes / No

Dizziness Yes / No Unexplained tiredness Yes / No Unexplained loss of gain of weight Yes / No

Have you ever had any previous body treatments or assessments including Chiropractic / Physiotherapy / Osteopathy / Massage / Acupuncture?

Type of Therapy_____

Outcome of Treatment_____

Do you do any form of exercise on a regular basis?_____

Have you ever had any type of accident? (RTA/ Horse Riding/ Sports related)_____

How much water do you drink daily?_____ Other fluids _____

What is your normal sleeping pattern?_____

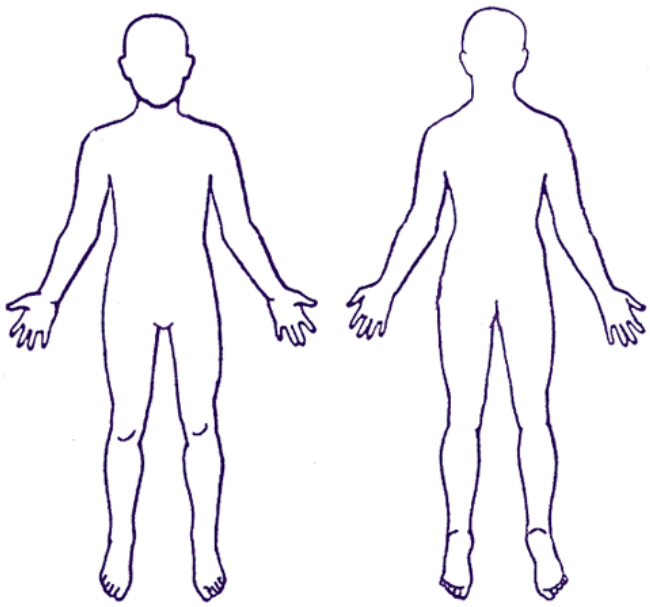
Do you have children? _____

Do you wear orthotics prescribed by a chiropodist or podiatrist or 'off-the-shelf' foot supports? Yes / No

Please describe the symptoms of your condition: _____

_____

What do you think caused your presenting issue? _____



Dental History: _____

_____

_____

Please tick:

☐ I have given Jihan Adem accurate information re my past and present medical history and my general health and wellbeing and I have agreed to treatment.

☐ I agree to tell Jihan about any changes to my health whilst I am receiving treatment from her. I have been told about any responses that could occur and have been made aware of any contra-indications to treatment by Jihan.

☐ I understand that there is a cancellation policy in operation and I expect to pay the full fee of an appointment if I cancel without giving 48 hours notice.

☐ I agree to my records being held electronically. All data is treated in the strictest confidence and processed in accordance with the General Data Protection Regulations (GDPR).

Client's signature_____

Therapist's signature_____ Date _____