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) _____

E mail address _____

Address _____

_____

D.O.B _____ Occupation _____

How did you find out about me/this treatment? _____

G.P. Name _____ Tel no _____

Address _____

_____

Condition Requiring Treatment _____

Have you had a Doctors 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 state past surgeries _____

Is there a history of the following for you or 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 _____

_____

Fever/Hot Flushes Yes ☐ No ☐ Sinus Yes ☐ No ☐

Chills Yes ☐ No ☐ Dizziness Yes ☐ No ☐

Unexplained tiredness Yes ☐ No ☐

Unexplained weight loss Yes ☐ No ☐ Gain Yes ☐ No ☐

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

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 chiropodist/podiatrist prescribed orthotics or "off the shelf" foot supports? Yes ☐ No ☐

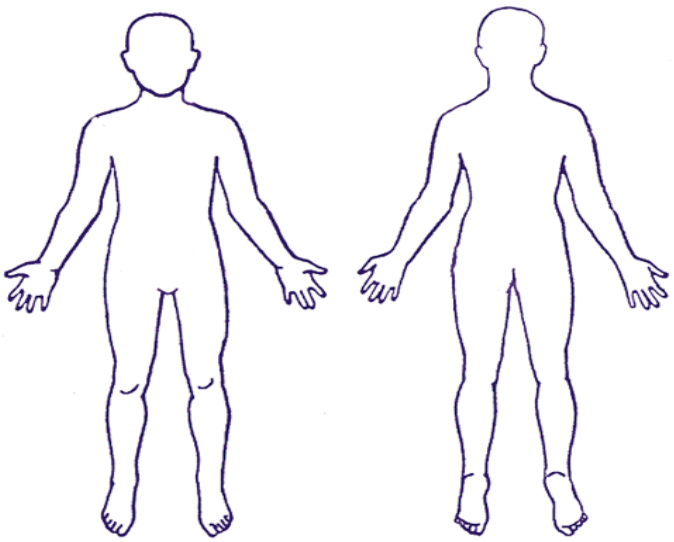
Please describe the symptoms of your condition _____

_____

What do you think caused your presenting issue? _____

_____

Please indicate on the diagram below any areas of concern



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 on an appointment if I cancel without giving 24 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 Signature _____

Therapist Signature _____ Date _____

Click here to submit form directly to Jihan ■

Or complete and e mail as an attachment to jihan@jihanadem.co.uk