Kate Fullerlove - Bowen Technique

Confidential Patient Record

Name: .... Date: ....

Address: .... Postcode: ....

Home Phone: .... Mobile: ....

Date of Birth: .... Age: .... Email: ....

Occupation: .... Hobbies/Recreation: ....

How did you hear about me? ....

GP Name & Address: ....

Marital Status: Single/Married/Defacto/Widowed/Separated/Divorced* Children? Yes/No* If yes, how many? ....

Briefly describe the health problem you would like to resolve: ....

....

....

Do you regard your health problem(s) to be ☐ Severe ☐ Moderate ☐ Mild

What other forms of therapy have you used to resolve your health problems? ....

....

How successful were they? ☐ Very successful ☐ Partly successful ☐ Not successful

Please list previous/other illness/accidents/surgery you have had: ....

How is your Sleep? ....

Have you had the Covid-19 injection? Yes/No* If yes, what date(s) ....

Type/Name of Covid-19 Injection received: ....

Did you have a reaction to any initially? If so, what? ....

IF FEMALE *Could you be pregnant?* *Yes / No** *If yes, how many weeks/months?* ....

Have you had any past pregnancies? *Yes / No** *If yes, how many and how long ago?* ....

Were there any complications with the birth(s)? ....

Menstrual cycle: ☐ regular ☐ irregular ☐ painful ☐ heavy ☐ menopausal ☐ post menopausal

Current medication *(Including any supplements or complimentary medications)*

Name of Drug	Dose	Frequency	Since when

What is your daily water intake? *(Not including fruit juice, soft drinks, tea, coffee, alcohol)*

☐ 2 Litres ☐ 1 Litre ☐ 500 ml ☐ less

Do you: Drink squash/low calorie drinks/use sweeteners/? **Yes** / **No***

If so, state what: ....

What are your favourite foods? ....

....

Are your bowel movements ☐ daily ☐ less than daily

How often do you exercise? ☐ daily ☐ weekly ☐ occasionally ☐ never

On a scale of 1-10 what is your daily energy level? ....

Do you smoke cigarettes? If so, how many per day? ....

Do you use orthotic appliances in your shoes (e.g. arch supports)? ....

Do you experience ringing in the ears, clicking/popping of the jaw or facial pain? ....

Do you have breast implants? ....

Please tick any of the following issues, which relate to you and place *two ticks* against those you would like to deal with:

Nervousness	Depression	Fears	Shyness
Sexual problems	Suicidal thoughts	Separation	Divorce
Finances	Drug use	Alcohol use	Friends
Anger	Self control	Unhappiness	Sleep
Stress	Work	Relaxation	Headaches
Tiredness	Legal matters	Memory	Ambition
Energy	Insomnia	Loneliness	Education
Concentration	Making decisions	Temper	Nightmares
Career choices	Inferiority	Marriage	Children
PMS	Unpleasant Memories	Thoughts	Parenting
Pain	Enemies	Social skills	Motivation
Regrets	Anxiety	Dizziness	Grieving

Is there anything else in your life that you would like to:

☐ stop doing ☐ start doing ☐ do better ☐ do differently

Please briefly explain ....

....

Do you have any medical conditions that may make you very poorly very quickly? e.g. epilepsy, etc., etc. If so, how would you need me to respond?

....

....

– *PAIN CHART* +
1 2 3 4 5 6 7 8 9 10

Please list areas of pain/problems on the right in order - worst first, and mark in red *(if possible)* on picture below.

R L L R

List of Problems

Please list in order below - worst first with pain level marked on a scale of 1 to 10

e.g. if you have a headache you may rate the pain $^{5}/_{10}$ or if the pain is variable, you may choose to rate it $^{5-8}/_{10}$

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All the information I have given above, regarding my case history, is true to the best of my knowledge, and I hereby agree to receiving treatment from Kate Fullerlove. I confirm that I have understood the treatment I am to receive and that I am willing to proceed without confirmation from my own GP or Consultant.

I consent to Kate Fullerlove keeping my personal details and records from each treatment in paper-based format only. This records treatment given, change in symptoms, and the continuity of any on-going treatment. These will be kept in a locked, secure filing cabinet for a period of time compliant with her Professional Insurance policy (currently 7 years after the last treatment), after which time they will be safely destroyed. I agree to her holding my telephone number(s) on her secure business phone (for use for appointment reminders) and understand that she will delete these within this same time period. The email address will only be used for contact if needed, not for marketing purposes, and not kept in an online address book. This is compliant with the new GDPR rules.

Signed: .... Date: ....

Name (printed): ....

The Bowen Technique is not intended as a substitute for medical advice or treatment
If in doubt, please consult your Doctor

* Delete as appropriate