

## Zen From Within Policies and Procedures

**Appointments:** At our office all sessions are by appointment only. To ensure appointment availability, a regular series of appointments is recommended.

**Cancellation Policy:** We know you have a busy schedule and that conflict and emergencies can come up. Our time together is very important. We do everything we can to accommodate your schedule. Please help us to provide better service for you and to be able to manage our waiting list by honoring our cancellation policy. **Unless there is an emergency, it is requested that you cancel your appointment 24 hours in advance or pay the missed appointment fee in full, as that time has been set aside specifically for you.**

If you currently have a package, you will forfeit one of the sessions on that package. Gift certificates may be forfeited for cancellations with less than 24 hours notice. Gift certificates will be forfeited for no shows and cancellations with less than 24 hours notice.

**Payments and Gratuities:** Payment is due at the end of all sessions. Zen From Within accepts cash, checks, credit cards, FSA and HSA cards. Payment is due at the end of the session. A \$25 fee will apply to any returned checks.

We kindly do not accept tips. The greatest tip you can give us is the gift of a referral. When you refer our work, you receive a \$10 referral bonus per person as a thank you.

**Package and Gift Certificate Policies:** All packages expire within 12 months of purchase date and can be shared with family and friends. Gift Certificates expire as stated on the certificate or within 12 months of purchase. No refunds are given for packages or gift certificates.

**Confidentiality:** All client information will be held in the strictest confidence.

My signature indicates that I have read and agree with the Policies and Procedures of Zen From Within.

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

## Bowen Therapy Intake Form

Name \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_

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

Phone \_\_\_\_\_

Occupation \_\_\_\_\_ Sports, hobbies \_\_\_\_\_

Emergency contact \_\_\_\_\_ Referred by \_\_\_\_\_

**Please check all that apply:**

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Abdominal / digestive problem     | <input type="checkbox"/> Chest pain                      | <input type="checkbox"/> Hamstring pain or tightness     | <input type="checkbox"/> Pain, other -- (location):<br>_____ |
| <input type="checkbox"/> Allergies / hay fever             | <input type="checkbox"/> Colic (baby)                    | <input type="checkbox"/> Headaches                       |  |
| <input type="checkbox"/> Arthritis -- (location):<br>_____ | <input type="checkbox"/> Constipation                    | <input type="checkbox"/> Heart problem                   | <input type="checkbox"/> Pelvic pain                         |
| <input type="checkbox"/> Asthma                            | <input type="checkbox"/> Diabetes                        | <input type="checkbox"/> Hernia                          | <input type="checkbox"/> Plantar fasciitis or neuroma        |
| <input type="checkbox"/> Ankle problem                     | <input type="checkbox"/> Diaphragm pain or tightness     | <input type="checkbox"/> Hip pain                        | <input type="checkbox"/> PMS or menopause                    |
| <input type="checkbox"/> Back pain -- (location):<br>_____ | <input type="checkbox"/> Diarrhea                        | <input type="checkbox"/> Hip replacement                 | <input type="checkbox"/> Pregnancy                           |
| <input type="checkbox"/> Bed wetting (children)            | <input type="checkbox"/> Dizziness                       | <input type="checkbox"/> Incontinence / bladder (adult)  | <input type="checkbox"/> Prostate problem                    |
| <input type="checkbox"/> Bone spurs                        | <input type="checkbox"/> Ear or eye problem              | <input type="checkbox"/> Infertility                     | <input type="checkbox"/> Rib pain / subluxation              |
| <input type="checkbox"/> Breast lump                       | <input type="checkbox"/> Edema, general                  | <input type="checkbox"/> Jaw / TMJ problem               | <input type="checkbox"/> Sacral pain                         |
| <input type="checkbox"/> Breast pain                       | <input type="checkbox"/> Elbow pain, tennis or golf      | <input type="checkbox"/> Joint replacement               | <input type="checkbox"/> Sciatica                            |
| <input type="checkbox"/> Breast implants                   | <input type="checkbox"/> Fatigue, chronic                | <input type="checkbox"/> Knee problem                    | <input type="checkbox"/> Scoliosis                           |
| <input type="checkbox"/> Bronchitis                        | <input type="checkbox"/> Fibromyalgia or polymyalgia     | <input type="checkbox"/> Liver problem                   | <input type="checkbox"/> Shin splints                        |
| <input type="checkbox"/> Bunion                            | <input type="checkbox"/> Fibroids - (location):<br>_____ | <input type="checkbox"/> Lung problem                    | <input type="checkbox"/> Shoulder problem                    |
| <input type="checkbox"/> Bursitis                          | <input type="checkbox"/> Fracture                        | <input type="checkbox"/> Magnet usage                    | <input type="checkbox"/> Sinus problem                       |
| <input type="checkbox"/> Buttock pain                      | <input type="checkbox"/> Gall bladder problem            | <input type="checkbox"/> Migraines                       | <input type="checkbox"/> Sleep / energy problem              |
| <input type="checkbox"/> Cancer                            | <input type="checkbox"/> Fallen on tailbone / coccyx     | <input type="checkbox"/> Numbness --(location):<br>_____ | <input type="checkbox"/> Tinnitus                            |
| <input type="checkbox"/> Carpal tunnel syndrome            | <input type="checkbox"/> Heating pad / ice pack usage    | <input type="checkbox"/> Orthodontia, extensive          | <input type="checkbox"/> Uterine or ovary problem            |
|  | <input type="checkbox"/> Heating / cooling salve usage   | <input type="checkbox"/> Orthotics in shoes              | <input type="checkbox"/> Wrist or thumb pain                 |
|  | <input type="checkbox"/> Hammer toes                     | <input type="checkbox"/> Osteoporosis                    | <input type="checkbox"/> Other:                              |

**Describe your condition(s), including length of time experienced. Please list all accidents, injuries, surgeries and falls that might be relevant in any way; include dates of occurrence. Continue on next page:**

---

---

---

---

---

---

---

---

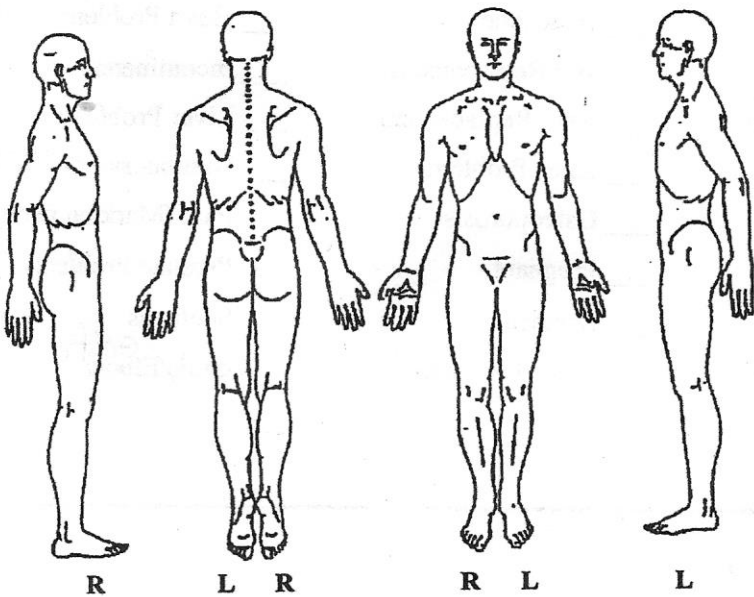
---

List activities compromised by condition(s):

---

---

Shade in the site(s) of pain on the anatomical drawing, and rate the severity of each pain on a scale of 1-10:



Neck ROM:
L
R
TMJ:
Shoulder ROM:
L
R

**Pain intensity scale –**

- (2) Mild pain (annoying, nagging)
- (4) Discomforting (troublesome, numbing)
- (6) Distressing (miserable, agonizing, gnawing)
- (8) Intense (cramping, dreadful, horrible)
- (10) Excruciating (tearing, crushing, unbearable)

Current medications (it is sufficient to state purpose, such as cholesterol, high blood pressure, osteoporosis):

---

Recent hands-on modalities received: \_\_\_\_\_

*I have stated, to the best of my knowledge, my known medical conditions. I understand that Bowen Therapy is given for the purpose of stress reduction, relief from muscular tension and/or spasm, facilitation of circulation and energy flow, and relief from stiffness. I understand that the practitioner does not diagnose illness or disease, nor treat specific physical or mental disorders. I will inform my practitioner of any changes in my condition, and will contact my practitioner should I have any concerns. I am responsible for paying for any appointment cancellation of less than 24 hours.*

Signature \_\_\_\_\_

Date \_\_\_\_\_