



Michael F. Harrison BS.ed, CBST

Core Balance Bowen Touch, Deep Tissue Massage & Professional Training
Comprehensive Mindfulness-Based Manual Somatic Touch Therapies
www.bowenpainrelease.com Telephone 510-525-1250

HEALTH / WELLNESS INFORMATION

Name _____ Date _____

Address _____ Phone (home) _____

City _____ State _____ Zip _____ (work) _____

(mobile) _____ **Email:** _____

Occupation _____

Age _____ Height _____ Weight _____ Date of Birth _____

How did you hear about us? _____

SUCCESSFUL HEALTH CARE AND PREVENTIVE MEDICINE ARE ONLY POSSIBLE WHEN THE PRACTITIONER HAS A CLEAR UNDERSTANDING OF THE PATIENT PHYSICALLY, MENTALLY AND EMOTIONALLY.

What are your most important health problems? List as many as you can in order of importance.

- 1)
- 2)
- 3)
- 4)
- 5)

Are you under the care of a physician? _____ Does she/he approve of you receiving bodywork/massage? _____

Are you on a medication prescribed by a physician _____ What? _____

Do you use Aspirin or any other non-prescription drugs? _____ Coumadin/Warfarin? _____

What and how often? _____

Do you wear contact lenses? _____ Have you ever worn braces? _____

Are you engaged in psychotherapy? _____ Do you have a spiritual practice? _____ What? _____

Women: Are you pregnant? _____

Any history of:	yes	no
Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Digestive problems	<input type="checkbox"/>	<input type="checkbox"/>
Genito-urinary condition	<input type="checkbox"/>	<input type="checkbox"/>
Mental/Emotional/Nervous condition	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory Condition; Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>

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Thank You for Referring Your Friends, Family and Colleagues

If you experience satisfaction in this Core Balance work, please refer people you care about. Michael offers presentation seminars & trainings at your organization, spiritual group, company, group of colleagues. Ask about sponsoring an event.

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Do you experience radiating pain in any limbs? _____ Numbness or tingling? _____

HABITS

Main interests and enjoyable activities: Do you exercise? Spend time outside? Have a supportive relationship? Have a history of abuse? Any major traumas?

How does this (health issue, condition) or complaint *if any*, affect you?

What do you think is happening in your health, , (thinking) or life situation that may contribute to it? why?

What do you feel needs to happen for you to get better?

What do you enjoy most in your life?

Is there any information about your health you would like to add? Please use back if needed.

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