



Pursuing the Ultimate Experience in
Athletic Achievement with Mastery
through Optimal Muscle Balance

(916) 834-1711

STRIVEBOWEN.com

A Subsidiary of Knowmor, Inc.

PATIENT REGISTRATION FORM

Patient's Name _____ Sex: M F (circle one)

Patient's Address _____
Street Apt # City State Zip

Mailing Address (if different from above) _____

Home Phone _____ Cell Phone _____ Work Phone _____

Patient's Date of Birth _____ Driver's License #: _____

Patient Referred By _____
Name Address Phone # Fax #

Current Employer _____ Occupation _____

Marital Status (circle one) Single Married Widowed Divorced Separated

Name of Spouse _____ Spouse's Phone # _____

If Patient is a Minor

Responsible Party _____

Relationship to Patient: Parent Step-Parent Other _____ (circle one)

Street Address _____
Street Apt. # City State Zip

Home Phone _____ Cell Phone _____ Work Phone _____

Mailing Address (if different from above) _____

Emergency Contact

Name and phone number of relative/friend who **does not** live with the patient

Name _____ Relationship _____

Phone _____

Primary Care Practitioner

Patient's PCP _____
Name Address Phone # Fax #



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FINANCIAL POLICY

Payment for services rendered are due at the time of service. Acceptable forms of payment: Cash, Check, Visa, Mastercard, and ATM/Debit. I understand there is a \$25.00 service charge for all returned checks. Balances older than 30 days may be subject to additional collection fees and interest charges of 1.5% per month.

You are responsible for the timely payment of your account. In the event any legal fees are incurred, as a result of non-payment for services rendered, they are the express responsibility of the client/patient.

NO-SHOW / CANCELLATION POLICY

This office has a no-show policy. Patients who do not call at least 24 hours before their appointment or do not show to their appointment will be charged the full therapy fee. I understand that I will be **charged** for not showing up to an appointment or not calling at least 24 hours in advance.

I have read and understand the statements above.

Signature of Patient / Responsible Party

Date

MEDICAL / LEGAL CARE

If your symptoms or presenting problem relates in any way to an existing motor vehicle accident for which you are being treated, your care is considered medical/legal. In that event, this information should be brought to the attention of the office management and/or your therapist and any care should be approved before therapy can be scheduled or performed. There are no exceptions. Thank you.

I have read and understand the statement above. _____(Please initial)

RELEASE OF INFORMATION

I hereby authorize the release of medical information requested by my insurance company or workers' compensation carrier. I also authorize the release of information to any hospital or physician I may be referred to by this office. I authorize assignment of payment directly to STRIVE™ for any covered major medical benefits due to me.

Signature of Patient / Responsible Party

Date

I understand that STRIVE™ practitioners do not diagnose illness, disease, or any physical or mental disorder, nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations. I acknowledge that this therapy is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service.

I have stated all medical conditions that I am aware of and will update the Bowen practitioner of any changes in my health status.

Signature of Patient / Responsible Party

Date

FOR OFFICE USE ONLY

Therapist Assigned _____

Date _____

HIPAA Information to Patient _____

STRIVE™

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CONFIDENTIAL HEALTH INFORMATION

Name _____ Height _____ Weight _____ Age _____ Date _____

In order that we may serve you better, please answer the following questions as best as you can.

☐ Requesting or Attending Practitioner or ☐ Recommended By _____

Have you had therapeutic bodywork before?

☐ Yes ☐ No If yes, how long ago? _____

Where? ☐ Professional Massage Office ☐ Chiropractor's Office ☐ Health Spa ☐ Other

Do you exercise regularly? ☐ Yes ☐ No What type of exercise or sport? _____

How many times per week? _____

Please check any of the following that apply to you. Have you had or do you now have?

- | | | |
|--|---|---|
| <input type="checkbox"/> Headaches/Shooting Pains | <input type="checkbox"/> Grating in Neck | <input type="checkbox"/> Indigestion/Gas |
| <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Tightness in Shoulder Muscles | <input type="checkbox"/> Constipation/Diarrhea |
| <input type="checkbox"/> Loss of Smell/Taste | <input type="checkbox"/> Nerve pain in Shoulders & Arms | <input type="checkbox"/> Gallbladder Trouble |
| <input type="checkbox"/> Hayfever/Asthma | <input type="checkbox"/> Pins & Needles in Arms & Hands | <input type="checkbox"/> Smoker / Packs per day _____ |
| <input type="checkbox"/> Tightness in Throat | <input type="checkbox"/> Cold Hands/Feet | <input type="checkbox"/> Liver Trouble |
| <input type="checkbox"/> Thyroid Trouble | <input type="checkbox"/> History of Tuberculosis | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Anemia | <input type="checkbox"/> Kidney/Bladder Trouble |
| <input type="checkbox"/> Twitching of Face | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Dialysis / History of |
| <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Nervous Stomach | Transplant _____ |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Head Feels Too Heavy | <input type="checkbox"/> Nerves & Nervousness | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Dizziness/Loss of Balance | <input type="checkbox"/> Inner Tension/Irritability | <input type="checkbox"/> Sleeping Problems |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Cold Sweats/Hot flashes | <input type="checkbox"/> Painful/Swollen Joints |
| <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Wear Glasses/Contacts | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Disc/Herniated Disc |
| <input type="checkbox"/> Dentures/Periodontal/Implants | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Pinched Nerves in Back |
| <input type="checkbox"/> Lights Bother Eyes | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Pins & Needles in Legs |
| <input type="checkbox"/> Muscle Spasm in Neck & Shoulder | <input type="checkbox"/> Heart Palpitations/Chest | <input type="checkbox"/> Pains in Legs & Feet |
| <input type="checkbox"/> Depression | Pounding | <input type="checkbox"/> Broken Bones, Fractures |
| <input type="checkbox"/> Panic Attacks/High Anxiety | <input type="checkbox"/> History of Heart Disease | <input type="checkbox"/> Other _____ |

Please list your current medications: _____

Please list any supplements you are taking: _____

Are you... ☐ pregnant ☐ currently under chemotherapy
☐ recovering from any recent surgery (within the last 12 months) If so, date? _____

Do you sleep on your... ☐ side ☐ back ☐ stomach

Do you wear... ☐ heel lifts ☐ sole lifts ☐ arch supports ☐ inner soles

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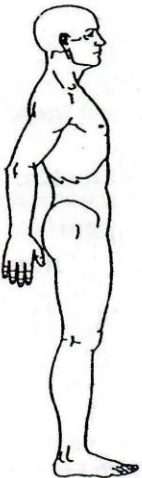
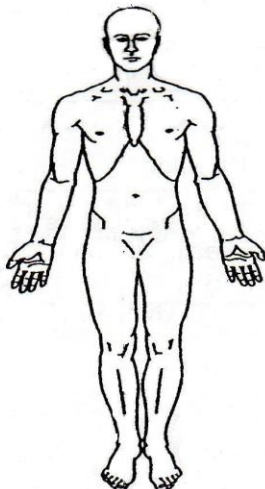
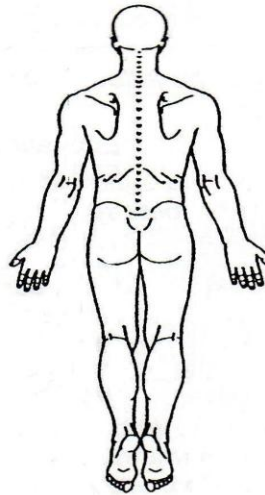
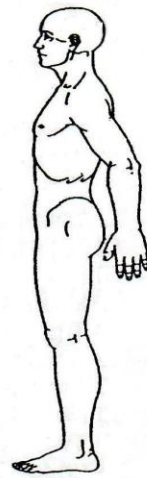
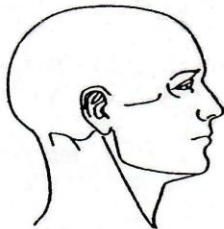
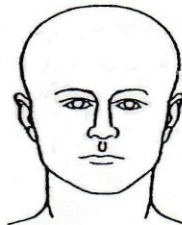
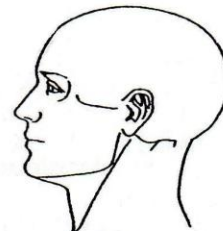
Name _____ Date _____

Date of Birth _____

Show by marking and drawing on the figures below where you are having most of your...

Aching or Pain **XXXX**Numbness or Tingling **OOOO**

Pins and Needles.....

Burning **////**Cramping **AAAA**Pain Movement or Shooting Pain **→→→→****Right Side****Front****Back****Left Side****Right Head****Front Head****Left Head**

The following questions are only an approximate assessment of your pain problem. We understand that exact descriptions are impossible. Please choose the responses that **BEST** approximate your **PAIN PRESENTLY** (over the last few weeks or months or longer).

1. Do you have more pain in your:

- ____ Back R L (circle)
 ____ Hip(s) R L (circle)
 ____ Leg(s) R L (circle)
 ____ Other _____

2. How often are you having pain now? (check only one):

- ☐ No pain or rarely have pain now
☐ Occasional pain (about once or twice per year or so)
☐ Recurrent pain (a few days every few months or more often)
☐ Frequent pain (a few days or more at least every month)
☐ Pain every single day (Is it constant? ☐ yes or ☐ no)

3. When having pain, it is generally (check only one):

- ☐ A mild discomfort or less
☐ A dull pain, worse at times
☐ A harder aching pain, frequently worse at times
☐ A severe pain, sharp and shooting at times
☐ A very severe pain, frequently very sharp, shooting and disabling
☐ An extremely severe and disabling pain

4. How is the pain now limiting your job, housework and social/recreational activities? (check only one):

- ☐ Not limited in any way
☐ Pain not bad enough to really limit me very much
☐ Able to work with pain all of the time by modifying my activities
☐ Must stop and limit activities, but able to work most of the time
☐ Frequently unable to work for several or more days at a time
☐ Unable to work at all – totally disabled by pain

Circle on number in each row below that most closely describes your level of pain at its LEAST BOTHERSOME and MOST BOTHERSOME.

Least Bothersome

0 1 2 3 4 5 6 7 8 9 10
 No Pain Extreme Pain

Most Bothersome

0 1 2 3 4 5 6 7 8 9 10
 No Pain Extreme Pain

Pain Factors

What makes the pain worse?

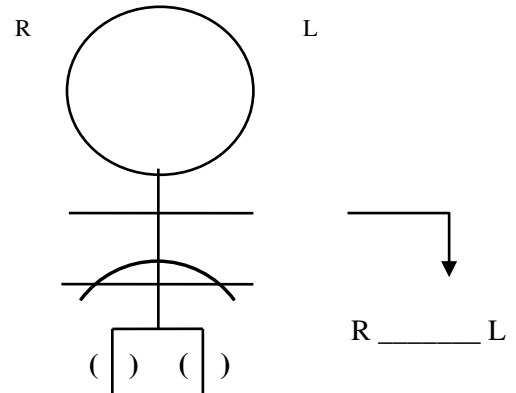
- | | |
|---|-----------------------------------|
| <input type="checkbox"/> Prolonged Standing | <input type="checkbox"/> Lifting |
| <input type="checkbox"/> Prolonged Sitting | <input type="checkbox"/> Bending |
| <input type="checkbox"/> Twisting | <input type="checkbox"/> Coughing |
| <input type="checkbox"/> Sneezing | <input type="checkbox"/> Walking |
| <input type="checkbox"/> Straining at Stool | |
| <input type="checkbox"/> Getting in and out of cars and/or chairs | |
| <input type="checkbox"/> Movement of _____ | |
| <input type="checkbox"/> Calf cramping: walking or at night | |

How far can you walk w/out stopping? _____ (distance)

Other: _____

What must you do to get relief? _____

THERAPIST'S ASSESSMENT



The following muscles/muscle groups are found to be hypertonic and will be addressed as needed:

- ☐ TMJ Joint
- ☐ Temporalis
- ☐ Occipitalis
- ☐ Suboccipitalis
- ☐ Sternocleidomastoid
- ☐ Ptergoid
- ☐ Masseter
- ☐ Scalenes
- ☐ Trapezius
- ☐ Rhomboid major
- ☐ Rhomboid minor

Rotator Cuff

- ☐ Teres minor
- ☐ Supraspinatus
- ☐ Infraspinatus
- ☐ Subscapularis

IT Band

- ☐ Tensor fascia latae
- ☐ Gluteus maximus

- ☐ A/C Joint
- ☐ Levator scapula
- ☐ Teres major
- ☐ Splenius group
- ☐ Deltoids
- ☐ Biceps brachii
- ☐ Triceps brachii
- ☐ Extensors of the arm
- ☐ Flexors of the arm
- ☐ Pectoralis major
- ☐ Pectoralis minor
- ☐ Latissimus dorsi
- ☐ Quadratus lumborum
- ☐ Erector spinae C / T / L
- ☐ Serratus anterior

- ☐ Gluteus medius
- ☐ Gluteus minimus
- ☐ Psoas
- ☐ Iliacus

Hip Rotators

- ☐ Gemellus's (2)
- ☐ Obturators (2)
- ☐ Piriformis
- ☐ Quadratus femoris

- ☐ Adductors
- ☐ Gracilis
- ☐ Sartorius

Quads

- ☐ Rectus femoris
- ☐ Vastus lateralis
- ☐ Vastus medialis
- ☐ Vastus intermedius

Hamstrings

- ☐ Semitendinosus
- ☐ Semimembranosus
- ☐ Biceps femoris

- ☐ Gastrocnemius
- ☐ Soleus
- ☐ Tibialis posterior
- ☐ Tibialis anterior
- ☐ Flexors of the calf
- ☐ Extensors of the calf
- ☐ Peroneals group
- ☐ Inguinal ligament
- ☐ Sacrotuberous ligament
- ☐ Patellar ligament

Personal Pain Assessment

Pre session _____

Post session _____

Assessment Outcome:

_____ Cervical-hyoid torsion/tension with restriction of: _____

_____ Contra-lateral hip torsion/tension with restriction R or L (circle one)

_____ Impingement syndrome with restriction of: _____

Home-based therapeutics discussed with good feedback demonstrated.

Client/patient to return for follow-up as agreed.

Therapist's signature _____

Date _____