Be Well Now
centre for bowen technique
homeopathic & naturopathic medicine

Confidential

Name:	Age:	Date of Birth:
Address:	City:	Postal Code:
Home Tel:	Mobile:	E-mail:
Children:	Ages:	
Occupation:	How Long:	Employer:
Referred by:	Insurance Provider:	

MAJOR COMPLAINTS IN ORDER OF IMPORTANCE FOR YOU?	SINCE?	CAUSES?

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING?	SINCE?	ANY ADVERSE EFFECTS?

CHECKMARK EACH OF THE FOLLOWING CONDITIONS YOU HAVE HAD:

Abscesses		Depression		Heart Disease		Pneumonia		Sunstroke	
Alcoholism		Diabetes		Hepatitis		Parasites		Stroke	
Allergies		Emphysema		Herpes		Prostatitis		Tonsillitis	
Anemia		Epilepsy		Kidney Disease		Rheumatic Fever		Tuberculosis	
Arthritis		Gall-Stones		Measles		Rheumatism		Urinary Tract Infection	
Asthma		Goitre		Miscarriage		Sexual Abuse		Warts	
Cancer		Gout		Mono		Skin Disease		Whooping Cough	
Chicken Pox		Gum Disease		Mumps		Strep Throat		Yeast Infection	
Cold Sores		Hay Fever		Pelvic Problems		Sinusitis		Yellow Fever	

ANY OTHER MAJOR CONDITIONS?	SINCE?	COMPLICATIONS?

OPERATIONS OR MEDICAL DEVICES?	WHEN?	COMPLICATIONS?

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OTHER ACHES & PAINS?	WHERE?	SINCE WHEN?

WHAT MAJOR INJURIES HAVE YOU HAD?	WHEN?	LONG-TERM EFFECTS?

WHAT VACCINATIONS HAVE YOU HAD?	WHEN?	ANY ADVERSE EFFECTS?

HOW MUCH OF THE FOLLOWING ARE YOU USING?

Coffee: Tea:	Alcohol:	Tobacco:	Recreational Drugs:

ARE YOU PREGNANT OR TRYING TO CONCEIVE?

DO YOU HAVE ANY OF THE FOLLOWING DEVISES?

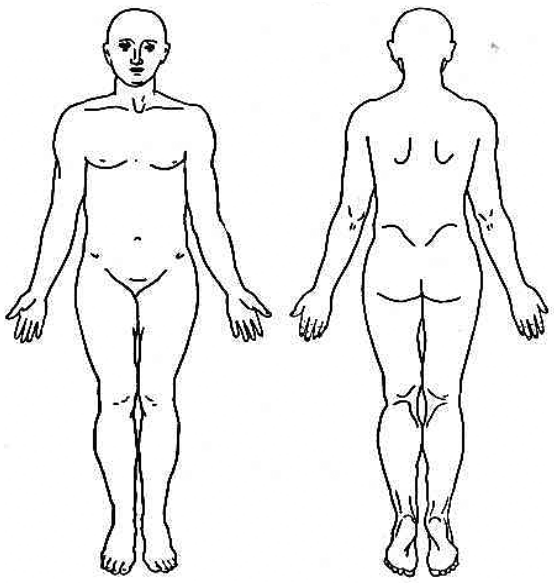
Dental Braces		Orthotics		Implants	
Dental Night Guard		I.U.D.		Other	

ARE YOU CURRENTLY UNDER THE CARE OF ANY OTHER PHYSICIANS or PRACTITIONERS?

Dr.	For:	Treatment:
Dr.	For:	Treatment:
Dr.	For:	Treatment:

PLEASE CIRCLE OR DRAW THE AREAS OF YOUR PAIN

WRITE BELOW TO HELP EXPLAIN THE HISTORY OF YOUR PROBLEM



I have read the Informed Consent Form of The Be Well Now Centre.

Signed: _____ Date: _____