LIVING WELL DALLAS | 14330 MIDWAY RD, SUITE 121, DALLAS, TX 75244 | 972-930-0260

First Name:	Last Name:	Date of Birth:
Prefer to be Called:	Marital Status (Circle): Single Married Partnered Widowed Separated	Age:
Street Address:	City:	State: Zip:
Preferred Phone (Circle): home work cell	Alternate Phone: home work cell	May we leave a message on your preferred phone? ○Yes ○No
Employer:	Occupation:	SS#
Emergency Contact Name: Emergency Phone(s):	Preferred email:	Primary Care Physician:
List any drug allergies:	Preferred Pharmacy:	List any food allergies:

What is your main reason for your visit today?

Which Services Interest You:

- ○ acupuncture
- ○ aromatherapy
- ○ Biofeedback
- ○ bio-identical hormones
- ○ Bowen technique
- ○ Chiropractic
- ○ craniosacral therapy
- ○ counseling/therapy
- ○ detox program
- ○ energy medicine
- ○ energy medicine
- ○ emotional freedom technique
- ○ frequency specific microcurrent
- ○ functional medicine
- ○ food allergies testing
- ○ health coaching
- ○ Healing Touch™
- ○ HeartMath™
- ○ life coaching
- ○ massage
- ○ men's health
- ○ nutritional testing
- ○ metabolic blueprint
- ○ nutrition counseling
- ○ organization
- ○ rapid eye technology
- ○ Reiki
- ○ walk & talk therapy
- ○ wellness
- ○ weight loss

Would you like to receive our newsletter? ○**Yes** ○**No** *(we will never sell your name)*

Cancellation & Re-Scheduling Policy

We understand that there are times when you will need to cancel and/or reschedule your appointment due to emergencies. We will do our best to accommodate your needs in such situations.

Please know that all cancellations and/or rescheduling requests must be made at least two business days prior to the date of your appointment. If a previously scheduled session is not cancelled or rescheduled within 24 hours of the time of the appointment, that session will be "missed" and charged for the full session fee. Thank you for your understanding.

( ) **I understand and accept this policy**

_____ _____

Your Signature **Today's Date**

Records and Privacy Policy: We will not release your records to anyone without your written consent. Because this is an integrated practice with multiple practitioners, we may facilitate care by having only one record per client. Coordinated care by your chosen practitioners will always be done with respect for your personal privacy and confidentiality.

( ) **I understand and accept this policy**

_____ _____

Your Signature **Today's Date**

LIVING WELL
:health & wellness center:
14330 Midway Rd | Bldg 1, Suite 121 | Dallas, TX 75244
Ph# 972.930.0260 | Fax# 972.559.3648

Client Information Form for Bowen/NST Treatment

(All information confidential)

Name:_____ Date:_____

Please circle any issues which relate to you (past or present) and check those you would like to deal with:

Breast implants	Operations	Nervousness	Loss of energy
Chronic illnesses	Traumatic accidents	Anxiety/Stress	PMS
Chronic viral infections	Low back pain	Sexual difficulties	Neck pain
Chronic fatigue	Dizziness	Fibromyalgia	Depression
Memory loss	Concentration	Alcohol use	Drug use
Nightmares	Insomnia	Headaches	Fears
Anemia	Arthritis	Cancer	Liver issues
Diabetes	Ulcers	Digestion	Circulation
Heart problems	Kidney problems	Lungs	Asthma
Prostate problems	Fainting	Bleeding	Hay fever
Hypoglycemia	Thyroid issues	Female problems	Yeast
Skin problems	Throat issues	Epilepsy	Hemorrhoids
Gallbladder	Breast	Colon	Constipation
Tumors/Cysts	Bladder	Parasites	Spleen
Pancreas	Swelling	Weight	Migraines
Allergies	Chronic diarrhea	Stroke	TMJ problems

Other _____

Do you regard your health problems to be (circle): severe moderate mild

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

How successful were they? _____Very _____Partially _____Not successful

Are you under the care of a medical doctor, chiropractor or other practitioner's care? _____
If yes, for what conditions? _____

Are you on any medications? _____ If so, please list_____
_____

Please briefly describe the health problem(s) you would like to resolve:_____
_____

Circle your daily water intake (*not including fruit juice, soft drinks, tea, coffee or alcohol*).
One gallon Half gallon Quart Half quart Less

How often do you exercise? Daily Weekly Occasionally Never
If regularly, what kind of exercise? _____

Please list supplements you are taking:_____
_____

The use of nutritional supplements can often dramatically increase your body's ability to heal and decrease your healing time synergistically. Do you want to discuss that? ____Yes ____No

You have bowel movements (circle): 3 or more daily twice a day
Once a day every other day several per week occasionally

Do you smoke?_____ If so, how much?_____

Do you wear orthotic appliances in your shoes? _____

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

If female: Are you pregnant?_____ If yes, how advanced?_____
Menstrual cycle (circle): regular irregular painful heavy menopausal other
Do you have children?_____ How many?_____ Do you have breast implants?_____

In case of emergency, please notify _____

Phone numbers: _____ or _____

I have completed this form to the best of my knowledge. I understand that the Bowen/NST therapeutic method is intended to be a health aid and in no way takes the place of a doctor's care when it is indicated. I understand that the practitioner does not diagnose illness, disease or any other physical or mental disorder. Likewise, the practitioner does not prescribe medical treatment or pharmaceuticals and does not perform spinal adjustments.

Signature _____ Today's date _____