Informed Consent Form for Bowen Therapy Treatment

Bowen Therapy - What to expect

During your Bowen Therapy session, you will lie relaxed on a treatment table and you will remain clothed. The Bowen therapist will apply a series of gentle movements across your body. There will be a minute break between each series of movements to allow you to achieve the deepest relaxation. The session usually lasts one hour.

The movements will focus on muscle, tendon or nerve and will release tension through the influence on nerve within that area being worked on. This produces results not only on the muscular level and the joints and skeletal alignment but also on functional systems such as digestion, breathing, lymphatic and vascular, therefore benefiting your overall wellbeing and vitality.

Bowen Therapy not only addresses your symptoms of today. It also positively affects you for many days to come. It is as if the treatment provokes a re-visiting of the way you are either coping or accommodating the problems in the first place and now there's a stimulus to deal with the symptoms more appropriately.

In fact, Bowen Therapy is remarkable not only for being simple but also for how quickly it works. We use Bowen Therapy as a first-line treatment for most major conditions as it relieves the majority of symptoms that have developed from these chronic conditions. This enables us to offer clearer and more direct treatments that address the causes of a disease as opposed to simply offering treatments to mask the symptoms.

After Bowen Therapy

- ☐ Drink as much water as feels right, to remain hydrated.
- ☐ Avoid strenuous activities, rest, recuperate and recover.
- ☐ Pain can be more focused for a short time and do take any of your usual medication choices as is needed.

I, the undersigned, do hereby acknowledge that I have been informed of and understand the therapeutic procedures and have discussed to my satisfaction this and any requests for related information with the Physician/Practitioner named above. As a result, I do hereby voluntarily consent for the recommended procedures specified above. I understand that I may change the status of my voluntary informed consent at any time.

Patient or Lawful Representative Full Name:_____

Signed:_____ Date:_____