

Registration

I herewith register for

Name/date of event

Name & Surname:

Address:

ZIP, town & country:

Phone / mobile:

Email address:

Date of birth:

Have you experienced Holotropic Breathwork before?

With whom?

Do you also speak German?

Insurance lies in the responsibility of the participants.

I have read and understood the information. I agree with the setting of this event, and I participate on my own responsibility.

Participation is only guaranteed my participation once we have confirmed it and received the workshop fee.

Place & date:

Signature:

The address to send this form to, and the bank details can be found on the website www.holotrop.ch under the corresponding workshop.

Medical form for Holotropic Breathwork

Holotropic Breathwork is intended as a personal growth experience and should not be looked upon as a substitute for psychotherapy.

Holotropic Breathwork is an intense and transformative work; it can involve dramatic experiences accompanied by strong emotional and physical release, requiring physical and psychological resilience.

The answers to the following questions are to assist your facilitators and will be kept strictly confidential. Please answer all questions as completely as possible

A. Do you have a past history of, have been diagnosed with, or are currently experiencing, any of the following?

	Yes	No
1. Cardiovascular disease, including heart attacks	___	___
2. High blood pressure	___	___
3. Diagnosed psychiatric condition	___	___
4. Recent surgery	___	___
5. Physical injuries that still inhibit you	___	___
6. Present or current infectious or communicable diseases	___	___
7. Glaucoma	___	___
8. Retinal detachment	___	___
9. Epilepsy	___	___
10. Osteoporosis	___	___
11. Asthma (If yes, please bring inhalator to the workshop)	___	___
12. Chronic headache/migraine	___	___
13. Aneurysm	___	___
B. Have you ever been psychiatrically hospitalized?	___	___
C. Are you currently taking any type of medication?	___	___
D. Have you ever been hospitalized for significant medical issues?	___	___
E. Are you currently in therapy or involved in any type of support group?	___	___
F. Is there anything else about your physical or emotional status we should be aware of?	___	___
G. Are you pregnant?	___	___

If you answer „yes“ to any of these questions, please specify in detail on the back of this page.

I hereby confirm that I have read and understood the above information, and have answered all questions completely and honestly, and have not withheld any information. My general health, as far as I am aware, is good.

Name: _____

Place & Date: _____ Signature: _____

Emergency contact information: Name _____ phone _____