

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.

To be guaranteed my participation has to be confirmed by the organisers, and the full fee has to be paid to our the account at Basler Kantonalbank:

Holder: Janina Schlettwein, IBAN: CH14 0077 0250 8775 1200 8, BIC: BKBBCHBBXXX

Place & date:

Signature:

Please return the completed registration and medical form to
Luccio Schlettwein, Socinstrasse 35, CH 4051 Basel, Switzerland, info@holotrop.ch

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

	Yes	No
A. Do you have a past history of, have been diagnosed with, or are currently experiencing, any of the following?		
1. Cardiovascular disease, including heart attacks?	___	___
2. High blood pressure?	___	___
3. Diagnosed psychiatric condition?	___	___
4. Recent surgery?	___	___
5. Past or recent physical injuries, including fractures and dislocations?	___	___
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 _____