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 the account 40-128794-5 in the name of Luccio Schlettwein at Postfinance (IBAN CH29 0900 0000 4012 8794 5, BIC POFICHBEXXX).

Place & date:

Signature:

Please return the completed registration and medical form to
Luccio Schlettwein, Socinstrasse 35, CH 4051 Basel, Switzerland
luccio.schlettwein@gmail.com

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. 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 _____