

Name (please print): \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_ Workshop Date: \_\_\_\_\_

### HEALTH CHECK FOR BREATHWORK PARTICIPANTS, 2017

*The Breathwork experience can involve intense experiences accompanied by powerful emotional and physical release. Pregnancy, cardiovascular disease, severe hypertension, a family history of aneurisms, recent surgery or fractures, acute infectious disease, seizure disorder, or certain psychiatric conditions are contraindications. So we can advise you properly, please answer the following questions. We will keep all your answers confidential. Your information will help us create a safe setting for this experience.*

- |  | YES | NO  |
|--|-----|-----|
| 1) Do you have any of the following?   |     |     |
| Cardiovascular disease, including angina or heart attack .....   | ___ | ___ |
| High blood pressure .....  | ___ | ___ |
| A family history of aneurisms .....  | ___ | ___ |
| A personal history of mental illness or psychiatric hospitalization ...  | ___ | ___ |
| Surgery, inpatient or outpatient .....   | ___ | ___ |
| Past or recent significant physical injuries .....   | ___ | ___ |
| Recent or current infectious or communicable diseases .....  | ___ | ___ |
| Glaucoma .....   | ___ | ___ |
| Retinal detachment .....   | ___ | ___ |
| Seizure disorder (epilepsy) .....  | ___ | ___ |
| Osteoporosis .....   | ___ | ___ |
| Back problems .....  | ___ | ___ |
| Sleep problems (apnea, snoring, etc.) .....  | ___ | ___ |
| Dietary restrictions (vegetarian, gluten-free, etc.) .....   | ___ | ___ |
| 2) Have you been advised (by a doctor or other health care provider) to restrict your physical activity in any way?..... | ___ | ___ |
| 3) Do you have asthma? (If you do, please bring your inhaler and call our attention to it at the workshop.) .....        | ___ | ___ |
| 4) If you are a woman, are you pregnant? .....   | ___ | ___ |
| 5) Are you currently in therapy or in a support group? .....   | ___ | ___ |
| 6) Are you currently taking any medication? .....  | ___ | ___ |
| 7) Do you have any other physical problems? .....  | ___ | ___ |
| 8) Is your general health good? .....  | ___ | ___ |
| 9) Is there anything else about your physical or emotional situation that you would like us to be aware of? .....        | ___ | ___ |

***Please use the back of this page to give details regarding any "yes" answers.***

***Mail this form along with a non-refundable \$25 deposit payable to "Elizabeth Gibson" to:***

***E. Gibson,  
128 Solar Park,  
Pawlet, VT 05761***

***Your registration will be confirmed.***

***Thank you!***

Please indicate your date of birth: \_\_\_\_\_

Confirm by signing here that you have understood and completely answered all questions. Thank you.

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Signature / Printed name

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Date