Boston Holotropic
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Cambridge, MA 02140

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617.834.9800

Workshop Information & Medical Form

This medical form must be received by your workshop organizer as part of your registration. We cannot send your confirmation of registration until we've received your signed medical form

Name ____

Address ____

City ______________________ State ________ ZIP __________

Telephone ____

Email ____

Emergency contact name _______________________________

Phone _______________________________

Please indicate any special dietary needs__________________________

Workshop Date(s) __________________________________

Location __________________________________

Payment
Amount $__________
❏ Paid using Paypal: Date ___________
❏ Check enclosed

__________ Received
__________ Interviewed
__________ Packet Sent

(If you've filled out one of these for us this year, and there are no changes, just say, "No Changes."
Please put any address changes--postal, email, or any comments on the other side. Thanks.)

MEDICAL INQUIRY FOR BREATHWORK PARTICIPANTS

The Breathwork experience can involve dramatic 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 about this, please answer the following questions. We will keep all your answers confidential. Your information will help us create a safe setting for this experience.

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

	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	___	___
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) Is your general health good?	___	___
8) Is there anything else about your physical or emotional situation that you would like us to be aware of?	___	___

Please indicate your date of birth: _________________

Please confirm by signing below that you have read, understood, and completely answered the above questions. Thank you.

____ ________________________

Signature / Printed name   Date

Mail to: Boston Holotropic • P.O. Box 400307 • Cambridge, MA 02140