Boston Holotropic
42 Linden Ave. #3
Somerville, MA 02143

info@bostonholotropic.com
617.834.9800

Workshop Information & Health Checklist

This form must be received as part of your registration. We cannot send your confirmation of registration until we've received your signed health checklist.

Name _____Pronouns_____

Address _____

City _____ State _____ ZIP _____

Telephone _____

Email _____

Emergency contact name _____

Phone _____

Please indicate any dietary preferences _____

Workshop Date(s) _____

Location _____

Payment
Amount $_____
☐ Paid using Paypal: Date _____
☐ Check enclosed

_____ Received

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

HEALTH CHECKLIST 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.

To 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	___	___
Recent 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, and will abide by the COVID testing policy. Thank you.

_____ _____

Signature / Printed name Date

Mail to: Boston Holotropic • 42 Linden Ave. #3, Somerville, MA 02143