ENVISIONING
&
REBIRTHING BREATHWORK

# PARTICIPANT INFORMATION SHEET

Name, first name: _____

DOB: _____

Phone: _____

Email: _____

Occupation: _____

Emergency contact name: _____

Emergency contact phone: _____

1. Are you currently taking medication? ☐ yes ☐ no

Please specify: _____

2. Are you currently taking any dietary supplements? ☐ yes ☐ no

Please specify: _____

3. Do you have a chronic illness? ☐ yes ☐ no

Please specify: _____

Please list the symptoms: _____

Current treatment: _____

Aftercare: _____

4. Do you currently have health problems? ☐ yes ☐ no

Please specify: _____

Please list the symptoms: _____

Current treatment: _____

Past treatment: _____

5. Do you have any fears or phobias? ☐ yes ☐ no

Please specify: _____

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6. Do you suffer or have suffered in the past of a mental illness? ☐ yes ☐ no

If yes, what type? _____

7. Are you currently on medication for a psychiatric disorder? ☐ yes ☐ no

Medicine and dosage: _____

Reason for medication: _____

8. Have you been diagnosed with seizures or epilepsy? ☐ yes ☐ no

If yes, are you on any medication? _____

9. Do you use stimulants and/or medication? ☐ yes ☐ no

If yes, which one? _____

10. Do you drink alcohol? ☐ yes ☐ no

Frequency? _____

If yes, how often? _____

11. Do you have a drug or alcohol addiction? ☐ yes ☐ no

Please specify: _____

12. Have you had any recent surgery or operation? ☐ yes ☐ no

If yes, what type of operation and when?

_____

_____

13. Do you have a cardiovascular problem? ☐ yes ☐ no

Please specify: _____

14. Is there anything about your body or mental state, that you think I should know about? ☐ yes ☐ no

If yes, please specify: _____

15. Do you already have breathing or rebirthing experience? ☐ yes ☐ no

If yes, ...

what method? _____

with whom and where? _____

when? _____

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With what success/
Result? _____

16. Are you informed about the meaning of the first 10 - 12 rebirthing-experiences? ☐ yes ☐ no

17. Do you have more negative or more positive thoughts about breathing in general?

negative ☹ ☐ 😟 ☐ 😐 ☐ 🙂 ☐ 😀 ☐ positive

18. What are your expectations, what is your goal with the Rebirthing Method?

_____

_____

_____

19. Do you currently have problems, limitations with (in) your body? ☐ yes ☐ no

If yes, which one? _____

_____

20. Are you currently undergoing medical, homeopathic, therapeutic or psychiatric treatment? ☐ yes ☐ no

If yes, which one? _____

What for? _____

I'd like to say something else:

_____

_____

_____

I hereby confirm that I have correctly and truthfully filled out the above mentioned participation form. If information in this participation form changes, I will inform my provider before I participate again.

_____
Name of the participant

_____ _____
Date Signature of the participant