



# 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: \_\_\_\_\_

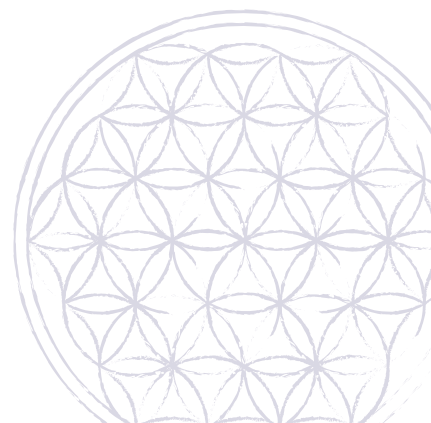
Please list the symptoms: \_\_\_\_\_

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: \_\_\_\_\_

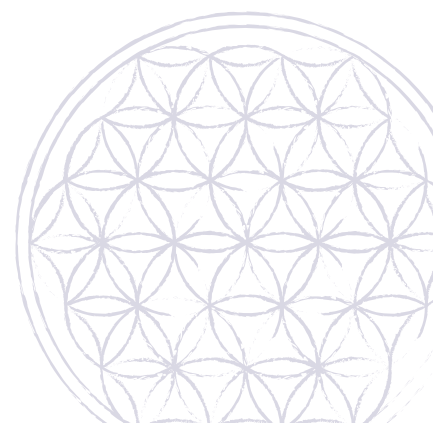
15. Do you already have breathing or rebirthing experience?  yes  no

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  yes  no  
or psychiatric treatment?

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

