

Confidential Medical Information Form

For Holotropic Breathwork™ Workshops

It is important that the facilitators be aware of your state of health. Certain medical conditions will limit your participation in breathwork. Your participation requires that this form is completed and received by a facilitator prior to the workshop. **The process is intended as a personal growth experience, and should not be looked upon as a substitute for psychotherapy.** Breathwork can involve dramatic experiences accompanied by strong emotional and physical release. This process is not appropriate for pregnant women, or for persons with cardiovascular problems, severe hypertension, severe mental illness, recent surgery or fractures, acute infectious diseases, or epilepsy. If you have any doubt about whether you should participate, consult your physician or therapist as well as the facilitators before attending.

The answers to the following questions are to assist your facilitators and will be kept strictly confidential.

Please answer all questions as completely as possible

1. Do you have a past history of, or currently suffer from any of the following

	YES	NO		YES	NO
a) High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	f) Any strain of Hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>
b) Recent surgery?	<input type="checkbox"/>	<input type="checkbox"/>	g) Sever mental illness	<input type="checkbox"/>	<input type="checkbox"/>
c) Retinal detachment?	<input type="checkbox"/>	<input type="checkbox"/>	h) Glaucoma?	<input type="checkbox"/>	<input type="checkbox"/>
d) Osteoporosis?	<input type="checkbox"/>	<input type="checkbox"/>	i) Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
e) Cancer?	<input type="checkbox"/>	<input type="checkbox"/>	j) Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
			k) H.I.V.?	<input type="checkbox"/>	<input type="checkbox"/>
l) Cardiovascular disease, including heart attacks	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
m) Past or recent physical injuries, including fractures or dislocations	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
n) Recent or current infectious or communicable diseases	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
o) Asthma (if "Yes" please bring your inhaler to the workshop)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
2. Are you currently pregnant?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever been hospitalised for medical reasons?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever been psychiatrically hospitalised?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
5. Are you currently in therapy or involved in any type of support group?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
6. Are you currently taking any type of medication?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
7. Were there any complications at your birth? Caesarean section? Anaesthesia	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have any history of addictions, or use of mind-altering drugs?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
• Have you used these within the past year?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
• If so, please indicate below what and when.	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
9. Is there anything else about your physical or emotional status of which we should be aware?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

Please elaborate on any "Yes" answers.

PLEASE READ AND SIGN THE FOLLOWING STATEMENT

I hereby confirm that I have read and understood the above information and have answered all the questions completely and honestly and have not withheld any information. My general health, as far as I am aware, is good.

Client Name: _____

Facilitator/Staff member: _____

Client Signature: _____

Signature: _____

Date: _____

Date: _____

In advance of the Workshop, Please complete and return this form to our Brisbane office

Purnata Kiora Pty Ltd
PO Box 7041 Holland Park East , Brisbane, QLD 41121
Tel 07 **3349 0706** Fax: 07 3349 0765
Email: admin@misso.com.au Web page www.misso.com.au

**COMMITMENT AND RELEASE FORM
For Holotropic Breathwork™ Workshops**

I
of
.....**Post Code:****Tel:**

hereby acknowledge that I understand that the aim of the workshop provided by Purnata Kiora Pty Ltd is one of deep self-exploration. It in no way claims to be a substitute for psychotherapy. I agree to participate in all aspects of the workshop, and I take full responsibility for all the effects of the processes used and any subsequent change in my life.

In consideration of being accepted to participate in this workshop conducted by Purnata Kiora Pty Ltd **I agree:**

1. That no illegal drugs will be brought to or used by me at the venue;
2. That I am responsible for my own health care;
3. That I will treat as strictly confidential whatever is personal to other participants;
4. That I remain for the entire period of the workshop in order to complete the process; and should I wish to leave early, I agree to discuss this with a facilitator;
5. That should a facilitator decide that the workshop is not appropriate for me, they have the right to terminate my participation;
6. That I will, after the workshop undertake not to use any of the processes, skills or techniques until completing the Grof Transpersonal Training;
7. I have read the contraindications in regard to Holotropic Breathwork sessions and have indicated on the attached Confidential Medical Information Form any conditions from which I suffer or have suffered, including medication;
8. I shall participate in the workshop atentirely at my own risk;
9. I hereby release Purnata Kiora its servants, officers and agents from all or any liability to myself or to any other person for injury, death, loss or damage to me or to my property howsoever or whosoever occurring during or as a consequence of my participation in the workshop;
10. I hereby indemnify and hold harmless Purnata Kiora Pty Ltd its servants, officers and agents against all or any claims, suits, proceedings, actions or demands for loss, injury or damage to person or property howsoever or whosoever occurring during or as a consequence of my participation in the workshop;
11. I understand that this process may involve some level of physical contact and hereby give consent for the facilitators to undertake such contact as deemed appropriate for my process;
12. I list briefly below any types of inner work I have done previously: _____

PLEASE READ AND SIGN THE FOLLOWING STATEMENT

I hereby confirm that I have read and understood the above information and have answered all the questions completely and honestly and have not withheld any information. My general health, as far as I am aware, is good.

Client Name: _____

Facilitator/Staff member: _____

Client Signature: _____

Signature: _____

Date: _____

Date: _____