

The Academy for the Love of Learning is excited to offer
HOLOTROPIC BREATHWORK™
Academy for the Love of Learning

APPLICATION

Please complete the entire form, including medical information,
and return the application to Patty Nagle, patty@aloveoflearning.org

PLEASE FILL IN:

HOLOTROPIC BREATHWORK DATES:

FULL NAME:

STREET:

CITY:

STATE:

POSTAL CODE:

TELEPHONE: (H)

(W)

MOBILE PHONE:

EMAIL ADDRESS:

DIETARY RESTRICTIONS:

PLEASE CHECK APPROPRIATE OPTIONS BELOW:

RESIDENTIAL - \$750 (Includes: Full Program, 3 nights accommodation-double occupancy, 3 breakfasts/3 lunches/3 dinners) – If single occupancy is available there would be an additional \$25/night fee.

I would opt for single occupancy if available

NON-RESIDENTIAL - \$595 (Includes: Full Program, 3 breakfasts/3 lunches/3 dinners)

Extra nights – please indicate if you would like to stay at the Academy for any extra nights (\$40/night double occupancy - \$65/night single occupancy)

Dates of extra nights:

SIGNATURE:

DATE:

(To be signed upon arrival at the Academy, we will print it out)

HOW DID YOU HEAR ABOUT THIS RETREAT?

HOLOTROPIC BREATHWORK™

PARTICIPANT INFORMATION & AGREEMENT

Holotropic Breathwork is intended as a personal growth experience, and should not be looked upon as a substitute for psychotherapy. This workshop is not appropriate for pregnant women, or for people with cardiovascular problems, severe hypertension, mental illness, recent surgery, broken bones or fractures, acute infectious diseases, or epilepsy. If you have any doubt about whether you should participate, consult your physician or therapist and the facilitators before attending.

The answers to the following questions are to assist the facilitators and will be kept strictly confidential. Please answer as completely as possible.

MEDICAL BACKGROUND - Do you have a past or current history of:

- | | | |
|-----|----|--|
| Yes | No | Cardiovascular disease, including heart attacks, any cardiovascular surgery and any cardiovascular symptoms such as arrhythmia or angina |
| Yes | No | High blood pressure |
| Yes | No | Strokes, TIAs, seizures, or other brain or neurological conditions |
| Yes | No | Have you had recent surgery |
| Yes | No | Have you ever been hospitalized for significant medical issues |
| Yes | No | Past or recent physical injuries, including fractures or dislocations |
| Yes | No | Recent or current infectious or communicable diseases |
| Yes | No | Glaucoma |
| Yes | No | Retinal detachment |
| Yes | No | Osteoporosis |
| Yes | No | Epilepsy |
| Yes | No | Asthma (if 'yes', please bring your inhaler to the workshop) |
| Yes | No | Are you currently pregnant? |
| Yes | No | Have you ever been diagnosed with a psychiatric condition? |
| Yes | No | Have you ever been psychiatrically hospitalized? |
| Yes | No | Have you ever or are you currently experiencing strong emotions or energies that made it difficult for you to function in daily life? |
| Yes | No | Are you currently in psychotherapy or involved in any kind of support group? |
| Yes | No | Are you currently taking prescription medication? Please list: _____ |
| Yes | No | Anything else regarding your physical or emotional status we should know? |

If you have answered 'yes' to any of the questions above, please explain your answer [at the end](#) of this form.

My health is generally good: Yes No

Age: Gender:

I have participated in a Holotropic Breathwork workshop before: Yes: No:

EMERGENCY CONTACT INFORMATION:

Contact Name:

Phone Number:

AGREEMENT:

I hereby confirm that I have read and understood the above information, and have answered all the questions accurately and completely. I am aware that emotional issues may be evoked during breathwork and that this workshop is not therapy. I understand that it is my responsibility to seek out professional emotional support if needed. In addition, I am aware that the breathwork process may invite physically stressful movement and that it is my responsibility to evaluate whether or not to engage in such movement based on my physical condition. My participation in this workshop is purely voluntary. I elect to participate in spite of the above-mentioned risks.

SIGNATURE

DATE

(To be signed upon arrival at the Academy)

PRINT NAME:

Additions to health questions: