

HEALING SPACE TRANSFORMATIONAL BREATH INTAKE FORM

Date _____ Referred by _____
Name _____ Date of birth _____
Address _____ City _____ State _____ Zip _____
Phone (Hm) _____ (Wk) _____
Email Address _____

Have you participated in a Transformational Breath session before? YES NO

Exercise (Type, How often) _____

Rate your general energy level (1-10) _____

Rate your general stress level (1-10) _____

What are your major stressors? _____

Please describe the nature of your birth (Normal, Cesarian, Unknown). Please include any known complications: _____

Are you currently experiencing any physical ailments? Please include any conditions, accidents, surgeries, etc, as well as dates in which they occurred:

Are you currently experiencing any mental/emotional issues? YES NO

If yes, please describe: _____

Are you receiving medical treatment or taking medication? YES NO

If yes, please describe: _____

Do you feel you express emotions freely? YES NO

What activities/practices do you participate in to center yourself? (Yoga, Meditation, Tai Chi, etc.) _____

What are your goals for your session(s)? _____

Are you currently struggling with any of the following addictions? (Smoking, Drinking, Food, Drugs—prescribed and/or illegal, Sex, Other) Please explain and include frequency: _____

Do you currently suffer from tiredness, headaches, stomach issues, pain, sleeplessness? Please explain and include frequency: _____

Do you currently experience anxiety, anger, isolation, depression, over reacting? Please explain and include frequency: _____

Do you have a good relationship with the following? (Yourself, Family, Friends, Others, Co-workers) Please provide answers for each: _____

I understand that the Transformational Breath (TB) sessions offered at Healing Space are intended to help reduce stress, improve restrictive breathing patterns, and support general wellbeing. I understand that the TB facilitator at Healing Space is not a doctor and does not diagnose illness, injuries, disease, or any other physical/mental/emotional issue. As such, the TB facilitator does not prescribe medical treatment or medications. I understand that the TB facilitator provides the service of teaching the TB technique only and that Transformational Breathing is not a substitution for medical examinations or treatment and that I should consult a physician for any physical ailment I might have. I will release the

Transformational Breath Foundation and any of its agents from any liability for what may or may not occur during my TB session.

Because the TB facilitator must be aware of existing physical conditions, I have stated all of my known medical conditions and take it upon myself to keep my TB facilitator updated on my physical health.

PLEASE NOTE THERE IS A 24 HOUR CANCELLATION POLICY. There is no charge for appointments cancelled more than 24 hours in advance of the scheduled time. Appointments canceled less than 24 hours ahead of time may be charged the full fee. A pattern of frequent late cancellations, even under unusual circumstances, will result in appointments being charged at full fee. Thank you for understanding.

Signature _____ Date _____