

Breathwork Session

INTAKE FORM

Check with **Y** for Yes or **N** for No all the fields:

- ☐ Do you have Epilepsy or experience/d seizures?
- ☐ Do you have/have you had glaucoma or a detached retina?
- ☐ Do you have/have you had any serious heart diseases/conditions?
- ☐ Do you have high or low blood pressure?
- ☐ Are you pregnant?
- ☐ Do you have osteoporosis?
- ☐ Do you have asthma? If so, do you use an inhaler?
- ☐ Do you have/have you had an aneurysm?
- ☐ Have you had a stroke?
- ☐ Are you on any blood thinning/anti-clotting medication?
- ☐ Have you ever been diagnosed with bipolar disorder or schizophrenia?
- ☐ Have you been hospitalized in the last 10 years for emotional crisis?
- ☐ Do you have/have you had PTSD?
- ☐ Sprains/strains/fractures
- ☐ Are you taking any heavy mind altering medication?
- ☐ Have you taken any recreational drugs or plant medicine in the last week?
- ☐ Do you have/have you had issues with addiction?

Thank you for filling this form out. It will help me ensure that you have the best experience possible.