HOCHOKA

RETREAT CENTER

BREATHWORK Package

v.1 2023

Holotropic Breathwork

Medical Information Form

Holotropic Breathwork is intended as a personal growth experience, and should not be looked upon as a substitute for psychotherapy. Holotropic Breathwork can involve dramatic experiences accompanied by strong emotional and physical release. This workshop is not appropriate for pregnant women, or for persons with cardiovascular problems, severe hypertension, severe mental illness, recent surgery or fracture, acute infectious disease or epilepsy. If you have any doubt about whether you should participate, consult with your physician or therapist as well as the facilitators before proceeding.

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

	YES	NO
1) Do you have a history of, or currently suffer from any of the following:		
a) Cardiovascular disease, including heart attacks	____	____
b) High blood pressure	____	____
c) Severe mental illness	____	____
d) Recent surgery	____	____
e) Past or recent physical injuries, including fractures or dislocations	____	____
f) Recent or current infectious or communicable diseases	____	____
g) Glaucoma	____	____
h) Retinal detachment	____	____
i) Epilepsy	____	____
j) Osteoporosis	____	____
k) Asthma (if "Yes," please bring your inhaler to workshop)	____	____
2) Are you currently pregnant?	____	____
3) Have you ever been hospitalized for medical reasons?	____	____
4) Have you ever been psychiatrically hospitalized?	____	____
5) Are you currently in therapy or involved in any type of support group?	____	____
6) Are you currently taking any type of medication?	____	____
7) Were there any complications at your birth? e.g. Caesarean section/Anesthesia	____	____
8) Is there anything else about your physical or emotional status of which we should be aware?	____	____

---- PLEASE ELABORATE ON ANY "YES" ANSWERS ON THE BACK OF THIS FORM ----

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'm aware, is good.

I understand that body work may be performed during the Breathwork session. If I do not want body work done, or if I want body work being done to me to stop, I will say "**Stop - I mean it!**" in order to indicate to the facilitator what my needs are. I understand that it is my responsibility to speak up for myself, and I am able to do that.

_____ _____ _____

Printed Name Signature Date

CONSENT TO PHOTOGRAPH, TAKE MOTION PICTURES, VIDEO TAPE, SOUND RECORD AND/OR TELEVISION

Parent/Guardian/Client

I hereby give Hochoka Retreat Center and or Kimberly Clarke the right to photograph, televise, film,video tape and/or sound record the acts, appearances and utterances of _____(Client Name) and to use any descriptive words or names, including the name of _____(Client Name) in connection therewith and without limit as to time, to produce and reproduce the same or any part thereof by any method and to use said photographs, films, video tapes and/or sound recordings for any purpose which Hochoka Retreat Center and Kimberly Clarke deems proper in the interest of newspapers, television media, brochures, pamphlets, instructional material, books and clinical material, medical education, knowledge and/or research. All such photographs, films and/or sound recordings shall be the exclusive property of Hochoka Retreat Center and Kimberly Clarke and I hereby relinquish all right, title and interest therein.

With respect to the foregoing, no inducements or promises have been made to me to secure my signature to this release other than the intention of Hochoka Retreat Center and Kimberly Clarke to use or cause to be used such photographs, films and pictures for the primary purpose of promoting and aiding Hochoka Retreat Center and Kimberly Clarke and its work.

Signature: _____ (Client, Parent or Guardian)

Date: _____

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Participant's Name: _____Date of Birth: _____Age:_____

Address:_____

Physician's Name: _____

Medical Facility:_____

Health Insurance Co.: _____

Policy No.:_____

Allergies to medications?

_____

Current medications:

_____

In the event of an emergency, contact:

Name: _____ Relation: _____ Phone:_____

Name: _____ Relation: _____ Phone:_____

Name: _____ Relation: _____ Phone:_____

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, and the above cannot be reach, I authorize Hochoka and or Kimberly Clarke to:
1) Secure and retain medical treatment and transportation if needed.
2) Release participants records upon request to the authorized individual or agency involved in the medical emergency treatment.

CONSENT PLAN
This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed
"'life saving" by the physician. This provision will only be invoked if the person above is unable to be reached.

Consent Signature :_____ _____(Client, Parent or Legal Guardian)

Date:_____