|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| First name |  | Last name |  | *photo – if acceptable* |
| Street |  | Place/Zip |  |
| Birth date |  | Country |  |
| Phone private |  | Age |  |
| Mobile phone |  | Gender |  |
| Profession |  | E-mail |  |
| Website |  | Skype |  |  |

*Fill in where applicable and send in due time* ***via surface-mail or personal delivery*** *please. All information is handled* ***strictly confidential*** *and serves your optimal support.*

* Are there changes regarding your family situation?

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* Or changes regarding your occupation?

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* What is your intention that you would like to explore?

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* I am able to participate in physical activities, I am in good physical, emotional and mental health: yes **\_\_** no **\_\_**
* Do you have any physical or medical condition that needs special consideration? yes **\_\_** no **\_\_**
If yes, which?

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* Are you taking medication? If yes, explain for which kind of condition. yes **\_\_** no **\_\_**

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* Are you currently consuming recreational drugs, nicotine or alcohol? What kind & how much per day/week?

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* Do you have other support/therapies/treatments? If yes, please name: yes **\_\_** no **\_\_**

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* Does your support have skills in the area of pre- & perinatal therapy? yes **\_\_** no **\_\_**
* Please list doctors or therapists where you are under treatment:

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* Are you currently pregnant? yes **\_\_** no **\_\_**
* Please insert yes or no as applicable and/or initial:

|  |  |
| --- | --- |
|  | I am responsible for my well-being. |
|  | I accept to give true information regarding important issues. |
|  | I agree to view or listen to any video or audio recordings by myself or group participants only. Sharing it with anybody else only with the written permission of the people present in the recording. *No other usage is permitted.* |
|  | ***For groups****:* May your contact data (address/phone/e-mail) be shared with other group participants? |
|  | ***For groups****:* I accept and retain confidentiality regarding any information concerning other group participants. |
|  | ***For groups****:* I will not consume nicotine, alcohol or recreational drugs during the workshop and at least one day prior to the group*.* S*ign with your initials.* |
|  | ***For groups****:* I will abstain from perfume and scented cosmetics during the workshop. |
|  | ***For groups****:* I agree that my data are being shared in case of co-facilitation with the co-facilitator. |
|  | ***For groups****:* I participate in the workshop from the beginning to the end. |

* How did your life change or what did you change since the last workshop?

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* Did you experience support being in contact with a participant of the last workshop?

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* What did you experience as supportive for your life in the last workshop?

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* Did you gain additional information regarding your birth or early life in/since the last seminar?

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* Any further information which you would like to share:

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* List resources you enjoy, which support or strengthen you when you have challenges, that is helpful or was helpful in the past?

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* List other Birth Process Workshops, that you have attended:

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| --- | --- | --- | --- |
| **Signature** |  | **Date** |  |

**Attachment:** Data protection policy in case not signed before *(Fill, sign & return together with this form)*