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| --- | --- | --- | --- | --- |
| 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 hand-over*** *please. All information is handled strictly confidential and serves your optimal support.*

* Who recommended this work to you?

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* Do you know anyone attending this workshop? And if yes, what is the nature of your relationship?

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* Family situation (married, living with partner, together, separated, how long, children, grandchildren) age/gender:

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* Are you a psychotherapist, bodyworker or do you work in an area of health care? yes **\_\_** no **\_\_**If yes, please describe your kind of praxis, trainings, therapeutic methods, clients per week etc.

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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 yes **\_\_** no **\_\_**
* 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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* Please insert yes or no as applicable and/or initial:

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|  | 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 only. Sharing it with anybody 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 group and at least one day prior to the workshop starts*.* 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 shared in co-facilitation workshops with the co-facilitator. |
|  | ***For groups****:* I agree to participate in the workshop all scheduled days, from the beginning to the end. |

* Are you taking medication? yes **\_\_** no **\_\_**   
  If yes, name medication and for which condition you are taking it please.

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* Are you currently consuming recreational drugs, nicotine or alcohol? If yes, what & how much per day/week?

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* Do you have experience with bodywork, individual or group therapy? yes **\_\_** no **\_\_**

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| If yes, which & how often? |  |

* Do you have other support/therapies/treatments? yes **\_\_** no **\_\_**

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| If yes, please name them |  |

* Does your support have skills in the area of pre- & perinatal therapy? yes **\_\_** no **\_\_**

If you do not have sufficient other support what are your plans to support yourself after the workshop?

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* Please list doctors or therapists where you are undergoing treatment:

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* Are you currently pregnant? yes **\_\_** no **\_\_**

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|  | If yes, what is the calculated due date? |

* Please tick or fill in what do you know or think is applicable regarding your birth.

My birth was:

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| --- | --- |
|  | un-medicated vaginal birth in a hospital |
|  | medicated vaginal birth in a hospital  If medication was used, which? |
|  | un-medicated vaginal birth at home |
|  | medicated vaginal birth at home? |
|  | under anesthesia |
|  | with forceps |
|  | with cranial suction |
|  | with fetal heart monitor |
|  | c-section |
|  | breech |
|  | a multiple birth |
|  | umbilical cord problems |
|  | other birth problems, please explain: |
|  | Do you want to add something? |

* Please tick what you know or think is applicable regarding your prenatal & birth history:

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|  | I was a premature. How many weeks? |
|  | I was in the newborn intensive care, how long? |
|  | I was in the incubator, how long? |
|  | I had a twin that did not live. When during pregnancy or after did the twin leave? |
|  | Was your father present during your birth? |
|  | Were you separated from your mother after birth? Did you stay in a nursery? |
|  | Were you breast-fed, how long? |
|  | Men: Were you circumcised as an infant? |
|  | Do you want to add something? |

* Were there interventions or hospitalizations shortly after birth? yes **\_\_** no **\_\_**

If yes, what do you know about it?

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* Please list surgeries or severe illnesses in your infancy or childhood.

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* Are you aware if one of your parents lost a child through miscarriage, abortion,   
  stillbirth or childhood death? yes **\_\_** no **\_\_**  
  If yes, are you aware how this affected you?   
  Do you know details of circumstances, when etc.?

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* Are your parents your biological parents? yes **\_\_** no **\_\_**
* Have you been adopted? yes **\_\_** no **\_\_**

If yes, what do you know about it?

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* Who raised you? Were you raised by one parent? If your parents separated, how old were you at that time? Did you have other primary care givers like grand-parents aunts, uncles, godparents, foster parents?

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* Do you have siblings? Please list age differences and your relationship as children.

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* Please describe any further knowledge about your conception and your parents’ attitude. Were you planned/un-planned/wanted/un-wanted/confused/was abortion considered/assisted conception such as IVF treatments?

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* What do you know about your life in the womb regarding physical or emotional influences, maternal or paternal smoking, drinking, drugs, mum’s nutrition or parents’ illnesses?

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* Was your father present during pregnancy and/or birth, how was the relationship of your parents during pregnancy, your sibling’s or family’s attitude towards your birth?

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* Have you lost a child through miscarriage, abort, stillbirth? yes **\_\_** no **\_\_**  
  If yes, please describe details and how it affects you today.

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* Have you been or are you in an abusive relationship? yes **\_\_** no **\_\_**

If yes, when?

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* In which relation was/is the person to you?

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* Is/was the abuse physical, sexual and/or emotional?

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* If concerning a past relationship what kind of action did you take? In a present situation which are your steps? Please give details.

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* Have you ever been prescribed medication regarding mental health reasons? yes **\_\_** no **\_\_**  
  If yes, please describe the circumstances and outcome with date.

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* Have you ever been hospitalized for mental health reasons? yes **\_\_** no **\_\_**  
  If yes, please give details of the circumstances and outcome with date.

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* Has anybody in your family attempted or committed suicide? yes **\_\_** no **\_\_**  
  If yes, please describe the circumstances with date.

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* Have you ever contemplated or attempted to commit suicide? yes **\_\_** no **\_\_**  
  If yes, please describe the circumstances with date.

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* Family information: dates of birth regarding parents/grandparents/great-grandparents in relation to possible war or refuge experiences.

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* Any further information which you would like to share:

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* What do you enjoy, what supports or strengthens you when you have challenges, what is helpful or was helpful in the past?

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

**Attachment:** Data protection policy *(Sign and return together with this form please)*