Life PRINCIPLES
for transformation

PERSONAL DETAILS, CONFIDENTIALITY CLAUSE & INDEMNITY FORM

Name: ____ Gender: [M] [F] Pregnant: [Y] [N]

Marital Status: _____________________No of Children: ______ Date of Birth: _______________________

Occupation: ____ Mobile: ____________________________

Address: ____ Email: _____________________________

(Physical) ____ Code: ______________________________

Emergency contact: ___________________________________ Cell: ______________________________

Allergies: ____ Mental State: _______________________

Dietary Requirements or Preferences: ____

Illnesses/Challenges: ____

Medications: ____

Dosage & time taken: ____

Do you have any chronic, ongoing pain that you deal with on a regular basis? What activities cause this pain and/or make it worse? How regular do you exercise and/or stretch and what exercises do you participate in?

____

Have you had any surgeries, hospitalization, or injuries? How long ago? Do you feel you have recovered from these events?

____

Have you experienced specific trauma e.g. death, family illness, accidents, or abuse? Do you feel you have properly processed it?

____

Have you ever consulted an alternative health worker? If yes, are you still in consultation.

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Are you presently or have you ever been under psychiatric or psychological care? If yes, for what reason?

____

How was your birth, have you given birth, and did you have a Caesar and/or an epidural?

____

How stressful is your life on a scale of 1-10? (1 being no stress)

Work: 1 2 3 4 5 6 7 8 9 10 **Life in General**: 1 2 3 4 5 6 7 8 9 10 **Intimate Relationships**: 1 2 3 4 5 6 7 8 9 10

Do any of the following conditions currently affect you or maybe during the last 3 years? (Mark relevant condition)

Lack of energy	Depression	Chronic Pain	Low Blood Pressure	Controlling
Chronic Fatigue	Sleep Difficulties	Headaches	High Blood Pressure	Abandonment
Restlessness	PTSD / Flashbacks	Lower Back Pain	Seizures/Epilepsy	Childhood Trauma
Over busy	Worry/Overthinking	Pelvic Pain	Cancer/Tumors	Financial Worries
Stomach Issues	Mood Swings	Sprains/Strains	Diabetes	Marital Stress
Fear / Terror	ADD/ADHD	Previous Broken Bones	Stroke	Psychiatric Illness
Anxiety / Panic	Nervous Breakdown	Osteoporosis	Fibromyalgia	Electrical Implant
Anger/Rage	Suicidal Thoughts	Arthritis	Heart Attack	Pacemaker
Any Addictions:	Smoking / Alcohol	Recreational / Sugar	Drugs / Other	Anorexia/Bulimia

Other health concerns not mentioned above and details regarding any addiction or substance abuse?

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What brought you here? Please state the reason for your interest in this Wellness Retreat. **This is important!**

____

I UNDERSTAND THE FOLLOWING:

1. Personal information will be handled in a confidential manner and Life Principles is POPIA compliant.
2. This Workshop and any treatments or sessions are of my own accord, and I accordingly indemnify the Facilitators from any harm, loss, or damages of any nature, whether bodily harm, trauma or any other damages to my person or property resulting from treatments or sessions, whether directly or indirectly.
3. All recommended supportive sessions are part of a comprehensive health and wellness system and is solely for use as part of a self-improvement and detoxification program.
4. None of the information provided during this Workshop is intended to act as a substitute for medical advice, nor does it involve the diagnosis, prognosis, or prescription of remedies for the treatment of any disease.
5. Disclosure is required by law where there is an intent to harm or endanger another person or oneself, or if I am being harmed by another person in any way, or if there is a reasonable suspicion of abuse or neglect.
6. I may be referred to other supportive professionals such as Psychologists, Counsellors, Journey Practitioners, TRE® Providers or other Therapists or Medical Practitioners should it be necessary.
7. TRE® and some other sessions, at times, require hands-on interventions. When this happens, I will be informed of exactly what is to be done and my permission will be requested.

I have read and understood the above. I take full responsibility of any decision, choices, and actions I make in conjunction with the support I receive, and therefore, absolve my facilitator/s from all liability. I affirm that I have notified my Facilitator or Therapist of all known medical conditions and injuries. I also understand that my facilitator/s will not disclose any information to assist clients in legal cases or matters.

☐ **I have read the above, understand everything and confirm all information to be true.**

TO BE SIGNED AT MEET AND GREET OF WORKSHOP ON DAY 1

______________________	______________________	______________
SIGNED BY DIRECTOR OF LIFE PRINCIPLES	**SIGNED BY DELEGATE**	**DATE**