



Rebirthing Breathwork Client Intake Form

Name	
Mobile/Home Phone no.	
Address	
City	
State	
Post Code/ZIP Code	
Today's Date	

Medical History

Please list any accidents, operations, medical treatments, medications you are taking:	
Infancy	
Childhood	
Teen	
Adult	

Medical Contraindications

- 1.Epilepsy
- 2.Detached Retina
- 3.Glaucoma
- 4.High Blood Pressure that is not controlled with medication.
- 5.Cardiovascular disease and/or irregularities including prior heart attack, pacemakers, arrhythmias
- 6.Prior strokes, seizures or any other brain/neurological conditions
- 7.If either you have had an aneurysm or if two members in your immediate family have had one.
- 8.Use of prescription blood thinning medications such as Coumadin
- 9.Acute somatic or viral diseases

10. Current pregnancy

11. Asthma (if you have asthma you can participate but you must have your inhaler available)

Please let me know if you have any of these contraindications.

Conception, Pre-Natal & Birth Information

Were you planned? Wanted?	
By both parents?	
Did your mother want a boy/girl?	
Did your father want a boy/girl?	
What number child are you Of?	
Any miscarriages or foetal deaths before your birth?	
Did your parents live together during your pre-natal life?	
What was the financial status of your family during you pre-natal life?	
What did your parents tell you about your pre-natal life?	
Any complications during your mother's pregnancy?	
Date and Time of Birth	
Place of Birth? Hospital or Home?	
Obstetrician? Male or Female?	
Anyone else present at your birth?	
Labour: easy, long, difficult, short?	
Other comments about labour:	

Where was your father during the birth?							
Please check all of the following that apply to your birth:							
<input type="checkbox"/>	Twin	<input type="checkbox"/>	Premature	<input type="checkbox"/>	Overdue	<input type="checkbox"/>	Forceps Delivery
<input type="checkbox"/>	Anaethetised	<input type="checkbox"/>	Vaginal	<input type="checkbox"/>	Caesarian	<input type="checkbox"/>	Breech
<input type="checkbox"/>	Separated	<input type="checkbox"/>	Blue Baby	<input type="checkbox"/>	Dry Birth	<input type="checkbox"/>	Cord Around Neck
<input type="checkbox"/>	Injury	<input type="checkbox"/>	Rh factor	<input type="checkbox"/>	Deformity	<input type="checkbox"/>	Placenta Previa
<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	Transfusion	<input type="checkbox"/>	Circumcision	<input type="checkbox"/>	
Is there anything else about your birth you'd like to add:							
Did your mother have any of these complications?							
<input type="checkbox"/>	Haemorrhage	<input type="checkbox"/>	Infection	<input type="checkbox"/>	Episiotomy	<input type="checkbox"/>	Post-partem depression
Anything else significant?							
Were you breastfed?		If not explain					
How did your other siblings react to your arrival?							
Any further comments?							

Infancy and Childhood Information:

Any illnesses, major accidents or injuries during or emotional traumas:	
During infancy?	
During childhood?	
During teenage years?	
Any deaths in your close family whilst growing up?	
Were your parents divorced? Separated or deceased?	
Describe your life as a child:	
List 3 things you liked about	

your mother:	
List 3 things you disliked about your mother:	
List 3 things you liked about your father:	
List 3 things you disliked about your father:	
Describe your parent's relationship while you were growing up:	
Were any significant others living with family? (grandparents, step-parents)	

Current Personal Information

Are you married/living with a partner? Living alone/shared house	
What do you enjoy about your relationship?	
Are there any problem areas in your relationship) communication, sex, money..	
Any problems with you body?	
History of problem	
Any other major tensions, pains or symptoms?	
Are you using any prescription, non-prescription or recreational drugs?	
For women: How many pregnancies? How many deliveries? Any problems with pregnancy	

or birthing?	
For men: Any infertility issues? Errectile dysfunction?	
Have you had present or previous psychiatric care?	
Have you received any other therapy present or previously?	
What self-improvement trainings, seminars or techniques have you done?	
What are your major fears? If any	
List 3 things you like about yourself	
List 3 things you dislike about yourself	
What in your life would you most like to change?	
What in your life would you like more of?	
What would you like to see manifest as a result of getting Rebirthed?	
Have you been Rebirthed before? If so, when? How many sessions?	
Do you have any fears about breathing, or reservations about Rebirthing?	
Do you have any questions about Rebirthing?	