TRUE SELF-LOVE SOMATIC WORKSHOPS

Application Form

This course is open to health therapists and practitioners who are wanting to do their own work so they can be more embodied and present for their clients.

We will be working with our early attachment experiences to deepen into our ability to truly love and accept ourselves. This will include our pre-conception experience as well as our experience in utero and our birth and perinatal experiences.

There is a two step process to apply to join True Self Love workshops. Fill out this form to apply, we will also do an interview either in person or over Skype prior to acceptance.

Confidential

Name: _____ **Date:** _____

Birthdate: _____

Profession: _____

Address:_____

Telephone: Home_____ **Work:**_____

Email: _____

Note: Many of the following questions are intensely personal. Your responses are completely confidential. If you are uncomfortable about responding to any of the questions please email me to discuss this: reneehella@gmail.com

What is your intention around coming to these workshops?

If you are a bodyworker, psychotherapist, health care practitioner or student in these fields, please indicate the nature of your practice or extent of training (types of therapy). If you do not work in the "healing" arts please give a short account of the work you do.

How long have you been practicing your type of therapy?

Some of the work may involve physical exertion. Do you have any medical conditions which would contraindicate involvement in this way?
Yes_____ No_____ If yes, please explain.

Are you presently taking any medications or drugs? (name of medication, for what condition?)

Are you presently using any recreational drugs, alcohol or nicotine? (amount per day/week).

Have you ever been prescribed medications for mental health reasons?
Yes_____ No_____
If yes, please describe the circumstances and outcomes, with the dates.

Have you ever been hospitalized for mental health reasons?
Yes_____ No_____
If yes, please describe the circumstances and outcomes, with the dates.

Have you ever experienced suicidal thinking or made a suicide attempt/s?
Yes_____ No_____
If yes, please describe the circumstances and outcomes, with the dates.

Are you being treated by any other health care professionals? Please give details.

Is there any history of mental illness, depression, chronic fatigue, autoimmune diseases in your family?

Have you ever been in an abusive relationship? Yes_____ No _____ If yes, please tell me about it…when, what relation the person was or is to you, whether the abuse was or is physical, sexual and/or emotional? If this was in a past relationship what action did you take? If in a present relationship what are you doing about it? Please give details.

Do you have any early abuse - sexual, emotional or physical? Please give details.

Please check what you know or think applies to your birth history. My birth was
_____ an unmedicated vaginal birth at home
_____ an unmedicated vaginal birth in the hospital
_____ a vaginal birth with anesthesia
_____ with forceps
_____with cranial suction (vacuum extractor)
_____ with a fetal heart monitor
_____ Cesarean Section Birth
_____ Breech birth
_____ a multiple birth (twin, triplet)
_____I was incubated. Please state how long, and what you know or think about the reasons for this

Have you ever had any eating disorders?

Do you have food intolerance, sensitivity, dietary restrictions?

Are you vegetarian or vegan or have you ever been vegetarian/vegan?

Do you have any autoimmune disease?

Do you have any digestive disorders, have you ever had digestive issues and have you ever had food poisoning?

I affirm that I have stated all my known medical conditions and health history details.

Name: _____

Signature: _____

Date: _____