

Transformational Bodywork Associates-Membership Application and Profile

Name: _____ Birth date: _____

Phones (H) _____ (Cell) _____ (W) _____

Address: _____

Email: _____ Emergency Contact: _____

Family of Origin: Birth order _____ Siblings (# & gender) _____

Marital Status: _____ Children (# & gender): _____

Occupation: _____ Hobbies: _____

Professional Degrees/Certifications/Classes Taken

Please respond to the following: *Continue on back or a separate sheet of paper if necessary*

1. Describe your personal growth experience and current state of physical and psychological health:

2. Describe any major childhood events that qualify your life experience today, and in what ways you are affected:

3. Describe any major adult experiences that have yet to be integrated or resolved in your life today:

4. Describe your current body/mind or meditation practice and how it relates to your current state of physical and psychological health:

5. Discuss your reasons for wishing to participate in this course

General Medical History: *Do you now, or have you in the past, experienced any of the following symptoms or conditions?*

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Frequent stress
<input type="checkbox"/>	<input type="checkbox"/>	Frequent headaches
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes- Type I or II?
<input type="checkbox"/>	<input type="checkbox"/>	High/low blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	Dietary constraints
<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Anxiety
<input type="checkbox"/>	<input type="checkbox"/>	Eating disorders
<input type="checkbox"/>	<input type="checkbox"/>	TMJ Pain
<input type="checkbox"/>	<input type="checkbox"/>	Grinding of the teeth
<input type="checkbox"/>	<input type="checkbox"/>	Back pain
<input type="checkbox"/>	<input type="checkbox"/>	Stabbing pain
<input type="checkbox"/>	<input type="checkbox"/>	Numbness
<input type="checkbox"/>	<input type="checkbox"/>	Touch or pressure sensitivity
<input type="checkbox"/>	<input type="checkbox"/>	Light or sound sensitivity
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Broken bones
<input type="checkbox"/>	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Major surgery
<input type="checkbox"/>	<input type="checkbox"/>	Are you in psychotherapy?
<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant?
<input type="checkbox"/>	<input type="checkbox"/>	Are you on any medications?

If you answered yes to any of these questions please explain:

To become a member:
Fill out this form and send it with your non-refundable \$100 deposit to:
Transformational Bodywork Associates
44800 Fish Rock Road
Gualala, CA 95445

Make checks payable to Transformational Bodywork Associates or TBA