*Somatic Dialogue - Class Registration*

*Janet Evergreen, MA*

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Course Date/Time:

Name:

Address:

Telephone Number:

Email:

Birthdate and Age:

Familial Status:

Occupation:

Emergency Contact Person and phone number:

▢ Check if you text message.

▢ Check if you are willing to share your phone and email contact. During Zoom if we lose connection this can be helpful to the assistants and your break out group.

▢ Check if you are a Bodyworker to request NCBTMB form to receive continuing ed credits.

▢ Check if you understand this is a somatic-based teaching and experiential inquiry. I \_\_\_\_\_\_\_\_ (name) will take responsibility for my own mental health and wellbeing during this class.

▢ Check if you agree to uphold confidentiality for this group.

▢ Do you wish to practice in person for this class when available?

▢ For those wanting to attend in person, are you fully vaccinated and able to provide your

vaccination card?

*Please answer the following questions:*

What is your intention for joining this class?

Who referred you or how did you find out about this class?

How much water do you drink daily?

What is your alcohol intake weekly?

Do you use Ceremonial Plant Spirit medicines that create an altered state,

for example, marijuana, ayahuasca? If so, how often?

How would you describe your diet?

What brings you the most joy, ease, inspiration, or sense of belonging in your life?

What or who supports you in personal growth?
(Example: walks in nature, therapist, family)

General Medical History

List diagnosed conditions

Describe any pain you are having (injuries or other) – include date of onset if possible.

Do you experience any of the following? (**Bold** your answer)

Yes No Headaches or migraines

Yes No Back pain

Yes No Jaw pain or clicking

Yes No Vision issues

Yes No Nightmares

Yes No Digestive issues

Yes No Do you grind your teeth at night?

Yes No Do you ever have trouble: falling asleep / staying asleep?

If you checked yes to any of the above, please explain in the space below: (location, frequency, duration, etc.)

Have you experienced any of the following within the last three years? (**Bold** your answer)

Yes No Hospitalization Heart problems

Yes No Stroke

Yes No High blood pressure

Yes No Cancer

Yes No Fibromyalgia

Yes No Disc problems

Yes No Sciatica

Yes No Arthritis

Yes No Carpel tunnel / Repetitive strain injury

Yes No Whiplash

Yes No Insomnia

Yes No Allergies

Yes No Skin Problems

Yes No Other

If you checked yes to any, please explain in the space below:

List medications, including non-prescription or recreational drugs you are presently taking.

Are you currently undergoing stress or going through an emotionally strenuous period in your life? If yes, what support do you have?

How would you rate your current level of stress? (**Bold** your answer, 10 is the highest):
1   2   3    4    5    6    7    8    9    10

Have there been any losses or big changes recently in your life? i.e: living situation, work, family, or relationship (**Bold** your answer) Yes No

When you reflect on the content of this course is there any relevant history you’d like to share?

Sometimes it is relevant to know your birth history (i.e. how you were conceived, anything you know was in the field you were born into). Share your birth story here or ask for our longer birth history form.

Other questions or comments related to this class?

Payment type (strike through box or **bold**):

▢Paypal ▢ Venmo ▢ Check ▢ Cash

To finalize registration: return form to Amanda, awwags@gmail.com
Send final payment by mail, Paypal (janet@janetevergreen.com) or Venmo (@Janet-Evergreen)

*Maling Address: Janet Evergreen 115 RiverBluff Circle, Charlottesville, VA 22902*