



**TRE® Medical Form**

**TYPE OF SESSION** (Please select the correct option with the letter **X**)

TRE® PRIVATE CLASS / SESSION: \_\_\_\_\_

TRE® GROUP CLASS / SESSION: \_\_\_\_\_

Full Name:
Date of Birth:
Age:
Email address:
Telephone - Home:
Cell:
Work:
Address:
Gender:                      Male <input type="checkbox"/> Female <input type="checkbox"/>
Occupation:
Marital Status:
Number of children
Medical Practitioner & Contact Number:
Medications & Reasons:
Dosage:
Length of time taken:
Allergies:
Emergency Contact Name:
Emergency Contact Number:

**MEDICAL HISTORY**

**Do you have any chronic, ongoing pain that you deal with on a regular basis? Describe what activities cause this pain and/or make it worse.**


**Are you currently in a state and do you have permission from your doctor to perform physical fitness exercises? i.e. walking, stretching, fitness training etc**

--

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


**Have you experienced trauma e.g. Death, Accidents, Sexual/Physical/Emotional/Mental Abuse? Please list them. There will be no need to talk about these traumas.**

1
2
3
4
5
6

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


**Do any of the following conditions currently affect you or have in the last 5 years?** (Please mark the applicable conditions with the letter **X**)

Lack of energy		Substance abuse		Lower back pain	
ME		Moodiness		Arthritis	
Fibromyalgia		Worry		Headaches	
Pelvic pain		Anorexia/Bulimia		Osteoporosis	
Pregnancy		Sexual difficulties		Cancer/tumors	
Pacemaker		ADD/ADHD		Sprains/strains	
Anxiety		Multiple personality		Diabetes	
Anger/rage		Fear/terror		Hypo or Hyperglycemia	
Depression		Psychiatric illness		Seizures/epilepsy	
Sleep difficulties		Bi-polar diagnosis		Cardiac/circulatory problem	
PTSD		Blood clots		High blood pressure	
Suicidal thoughts		Heart attack/stroke		Low blood pressure	

**Are there any other health concerns not mentioned above that are important to mention prior to performing the TRE® exercises?**


**Please state your reason for embarking on the TRE® process i.e. anxiety, pain, muscle tension release etc.**


**CONFIDENTIALITY CLAUSE:**

Everything discussed within the confines of the time of work together shall remain confidential and shall not be divulged to any third party by your TRE® facilitator/provider. If participating in group work, no identifying material to be divulged outside of the group.

**CANCELLATION CLAUSE:**

I agree to give a minimum of 24 hours (1 full day) cancellation notice if my participation in a TRE® online session or workshop is to be cancelled or changed. Failure to do so will result in full payment of the missed session, without a credit. A credit is only applicable under the aforementioned conditions, minus administration and bank charges. Late arrival will result in reduction of TRE® session or workshop time while the full fee will apply.

Eneegma reserves the right to cancel a session, event or workshop due to low enrollment, inclement weather or other circumstances or reasons beyond our control which would make the event non-viable. If Eneegma cancels an event or session, we will do everything we reasonably can to let you know and registrants will be offered a full refund. Should circumstances arise that result in the postponement of an event, registrants will have the option to either receive a full refund or transfer registration to the same event at the new, future date.

**INDEMNITY:**

I undertake this treatment of my own accord and accordingly indemnify the TRE® facilitator/provider from any harm, loss or damages of any nature, or any other damages to my person or property resulting from the treatment, whether directly or indirectly.

**TEACHING EXERCISES:**

If I am not a Certified TRE® Provider, I acknowledge and accept that I am NOT qualified to lead others through these exercises and that I will only use them for myself.

I have read and understood the above and confirm it to be true.

Date Signed	Full Name	Signature
	Client:	
	Practitioner/Provider:	