The Hoffman Process Enrolment Form

In order for us to confirm your place on the Process, we ask that you complete all the information on this form and return it either by post to the address at the end or scan it to enrolment@hoffmaninstitute.co.uk as soon as possible.

Personal Information

Name: _____ Process date: _____

Date of Birth: _____ Age: _____

Gender: _____ Nationality: _____

Occupation: _____ Company/Position: _____

Address: _____

Mobile No: _____ ☐ *(tick preferred number)*

Home Tel: _____ ☐

Email: _____ Skype: _____

How/from whom did you first learn about the Hoffman Process? *(Please specify name)*

_____

Arrival and Accommodation

You are registered for a Process at **Oxon Hoath**, Oxenhoath Road, Hadlow, Kent, TN11 9SS.
Contact details for Oxon Hoath: 01732 811071, admin@oxonhoath.co.uk, www.oxonhoath.co.uk

Registration is on Saturday between 9 and 9.30am. The course finishes at 2pm the following Friday.

If you wish to arrive earlier, you may stay on the Friday night. Please arrive between 4 pm and 9.30pm.
There is an additional charge for Friday night: Bed and Breakfast = £72.00 With Dinner = £89.00
If you are delayed or your plans change, please contact Oxon Hoath to avoid incurring a charge.

I will arrive on Friday ☐ I would like Dinner (*Dinner is served at 7pm*) **Yes** ☐ **No** ☐

I will arrive on Saturday ☐

Accommodation is shared with 1-2 other people of the same gender. Do you snore? **Yes** ☐ **No** ☐

Dietary Requirements

Oxon Hoath provides nutritious, wholesome food throughout the week. We do not recommend that you use the week to detox or change your diet.

Are you vegetarian? **Yes** ☐ **No** ☐ Do you eat fish? **Yes** ☐ **No** ☐ Do you eat pork? **Yes** ☐ **No** ☐

Oxon Hoath will cater for the following diets by special arrangement at an extra charge of £55 per week.

☐Vegan ☐Gluten free ☐ Wheat free ☐ Dairy free ☐ Lactose free

Please specify allergies or other dietary information: _____

Please call Oxon Hoath in advance to pay for additional accommodation and special diets.

Emergency Contact Information

1. Please provide contact details of one person who knows you are participating in the Process.

Name: _____ Relationship: _____ Tel: _____

2. Please provide an additional contact.

Name: _____ Relationship: _____ Tel: _____

Office Use only: Contact Details Checked? _____ History Checked? _____
GP Guidelines: Needed ☐ Sent ☐ Therapist Guidelines: Needed ☐ Sent ☐

YOUR APPLICATION TO PARTICIPATE IN THE HOFFMAN PROCESS:

We realise that the questions on this form may bring up sensitive issues, and we ask you to please answer as honestly as possible. Your application is confidential and your answers will help us to assess whether there is any reason why you should *not* participate in the Process for your own well-being. It is not possible for us to predict any participant's experience, or the effect of the Process on them, but if we feel that for any reason it is not appropriate for you to attend, we will try to recommend an alternative course or treatment. Your deposit would be refunded to you at that point. The Hoffman Institute must approve this enrolment form to confirm your place on the Hoffman Process.

In some cases we may require that you contact a Doctor or Therapist before you participate in the Process.

Please ensure that you have read and fully understand and agree to our Terms & Conditions (found with your registration documents) as they contain information about our cancellation policies. Please note that you will be required to sign a Declaration & Consent Agreement on the day of your arrival.

It is a condition of your participation that you notify us before starting the course if there are any changes to the information you have provided.

If you have any questions please contact the office on: 01903 88 99 90

Your submission of this form confirms that you understand and agree to be legally bound by these terms and also agree that the information given is true and accurate.

Confidential Health Information

1. Has a Doctor or other practitioner ever treated you for, or told you that you have:

Please answer Yes or No	Yes	No		Yes	No
Tumour/Growth/Cancer	☐	☐	Epilepsy	☐	☐
Allergies	☐	☐	Dizzy spells	☐	☐
Liver trouble	☐	☐	Convulsions	☐	☐
Shortness of breath	☐	☐	Loss of consciousness	☐	☐
Chest pain	☐	☐	Paralysis	☐	☐
Stroke	☐	☐	Brain concussion	☐	☐
Rheumatic fever	☐	☐	Severe/frequent headaches	☐	☐
Heart trouble/murmur	☐	☐	Diabetes	☐	☐
Low/High blood pressure	☐	☐	Joint or muscular disorder	☐	☐
Any digestive tract disorder	☐	☐	Loss of hearing	☐	☐
Gallbladder disease	☐	☐	Vision impairment	☐	☐
Kidney disorder	☐	☐	An infectious disease	☐	☐

If you answered yes to any of the above, please can you provide us with more information, including dates and treatment received: _____

_____

2. Have you ever had any significant injuries, diseases or surgery? .....Yes ☐ No ☐

If yes, please provide more information: _____

_____

3. Do you have any reason to believe that you are not in good health? .....Yes ☐ No ☐

If yes, please provide more information: _____

_____

4. This course involves some vigorous bodily movement and physical activity.

Do you have any physical limitations that might affect your ability to participate?.....Yes☐ No ☐

If yes, please provide more information: _____

_____

5. Do you have any physical issues that are aggravated by emotional stress?.....Yes ☐ No ☐

If yes, please provide more information: _____

_____

6. Are you taking any prescribed medication for any of the above? ..... Yes ☐ No ☐

Name(s) of medication(s) and how long have you been taking it? _____

_____

7. How many hours of sleep do you normally get? _____

8. Have you ever suffered from insomnia/sleep disorder?..... Yes ☐ No ☐

If yes, please provide more information: _____

9. Are you on any sleep medication, prescribed or otherwise? ..... Yes ☐ No ☐

If yes, please provide more information: _____

10. Do you have a reading or learning disability? .....Yes ☐ No ☐

If yes, please provide more information: _____

11. Are you pregnant?..... Yes ☐ No ☐

If yes, how many weeks and is it your first pregnancy? _____

If you are pregnant we will require you to consult with your doctor and contact the office before we accept you on the Hoffman Process. If you become pregnant between completing this application and attending the course, you must consult your doctor about attending and confirm this with us.

12. Do you drink alcohol? .....Yes ☐No ☐

If yes, how much? _____How often? _____

13.Do you use recreational drugs? ..... Yes ☐ No ☐

If yes, which drugs? _____ How often? _____

In order to gain the most from the course, we ask that you refrain from alcohol and any substances which may affect your concentration or ability to access your feelings, for at least two weeks before the course starts and throughout the duration of the course. For your own safety and the safety of others it is a requirement of the Hoffman Institute that you do not bring alcohol or recreational drugs to the Process venue. If you breach or break this agreement you will be asked to leave the Process and premises.

14. Do you have, or have you ever had an eating disorder? .....Yes ☐ No ☐

If yes, please provide details including dates:

_____

15. Are you in a recovery programme for any of the above?.....Yes ☐ No ☐

Name of recovery programme(s): _____

How long have you been in recovery? _____

Doctor

Please provide the name of your Doctor in case of emergency:

Name: _____Phone Number: _____

Address: _____Email: _____

We have guidelines about the Hoffman Process that we send out to health professionals. Would you like us to send some to your doctor? ***Yes please*** ☐

Emotional Wellbeing

16. Are you currently in therapy? .....Yes ☐ No ☐

When did you start going and what type of therapy is it?

_____

How often do you see your therapist? _____

What issues are you seeing your therapist for and how are you benefiting? _____

_____

Please provide details of your therapist. We will not speak to them without your permission.

Name: _____Phone Number: _____

Address: _____

Email: _____

It is standard practice to send Process guidelines to your therapist. The information will also help your therapist support you before and after the Process. Please tick this box if you would **NOT** like us to send guidelines to your Therapist ☐

17. Have you been in therapy in the past? ..... Yes ☐ No ☐

When and how often did you go? _____

What kind of therapy was it? _____

What issues were you seeing your therapist for and how did you benefit? _____

18. Have you ever been diagnosed with a psychological condition or psychiatric illness?.....Yes ☐ No ☐

Please provide more information including dates, who it was diagnosed by and treatment

_____

_____

19. Have you ever been hospitalised for a mental disorder? ……..……Yes ☐ No ☐

Please provide more information including dates, diagnosis and treatment

_____

_____

20. Have you ever had a 'nervous breakdown'?……..……Yes ☐ No ☐

Please provide more information including dates, diagnosis and treatment

_____

_____

21. Have you ever suffered from or been treated for PTSD or any other traumatic response?…Yes ☐ No ☐

Please provide more information including dates, diagnosis and treatment

_____

_____

What professional support have you received?

_____

_____

22. Are you currently taking any prescribed medication, which is commonly used for emotional illness, anxiety or depression? ..... …….. Yes ☐ No☐

Medication: _____ Dosage: _____

23. Have you previously taken such medication? …… Yes ☐ No☐

Medication: _____Dosage: _____

24. Did either of your parents or surrogate parents suffer from a major psychiatric disorder during your childhood? (e.g. Schizophrenia, Bipolar Disorder/Manic Depression, Major Depressive Disorder, Psychosis or Personality Disorder)..... Yes ☐ No ☐

Please provide details: _____

_____

_____

25. Have you experienced bereavement within the last 12 months? If so, please give details .. Yes ☐ No ☐

Relationship to person: _____Date: _____

26. Have you ever attempted suicide? ..... Yes ☐ No ☐

If so, at what age: _____

Circumstances: _____

27. Did you experience physical abuse as a child? ..... Yes ☐ No ☐

If so, at what age: _____Circumstances: _____

_____

_____

28. Have you ever experienced sexual abuse? ..... Yes ☐ No ☐

If so, at what age: _____Circumstances: _____

_____

_____

29. If you answered 'yes' for any of questions 25 – 28, what professional support have you received?

_____

_____

_____

30. What would you say are your current main sources of stress? For example, current relationship/family problems, separation, divorce, work stress, illness, bereavement, addictions, major life changes.

_____

_____

_____

31. What do you consider to be the most traumatic or distressing event in your life and when did it occur?

_____

_____

_____

32. What do you hope to gain from your week on the Hoffman Process?

_____

_____

_____

_____

Please confirm that you have read our Terms and Conditions by ticking the box: ☐

http://www.hoffmaninstitute.co.uk/booking-terms-and-conditions/

Next Steps

If you have not already spoken with one of the enrolment team, we will be in touch to arrange a convenient time to discuss the Process further.

Six weeks before the start of your course we will email you the pre-course work. This work is designed to teach you the essential concepts of the Hoffman Process and your responses will form much of the content of the first days of the course. We ask you to complete it comprehensively and with careful attention to each section. Your course work must be returned to the Hoffman Institute *at least 2 weeks* before the start of your course in order that one of the Hoffman teaching team has time to read it before arranging to speak with you.

Thank you for completing this form. Please remember to save a copy with your name and email it back to the office as soon as you can.

Please return this completed form to: enrolment@hoffmaninstitute.co.uk

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