

The Warrior Monk Training

PO Box 1378, Freeland, WA 98249

Date/location of training you are
registering for:

Registration and Information Form

All information on this form will be kept completely confidential; and will be seen only by the workshop leaders.

Name: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Email: _____ Relationship Status: _____

Work / Profession: _____

Emergency Contact: _____ Phone: _____

How did you hear about The Warrior Monk Training?

Personal

What kind of personal development work have you done in the past? Workshops, spiritual retreats, psychological work, etc?

What is it that you hope to receive for yourself from this retreat?

Please share a little about why this retreat seems like a good, next step for yourself?

Are you presently going through any particular challenging life issues you are willing to share? (health, emotional, big life-change, transition etc...)

Confidential Medical and Health Information

1. Are you under a physician's care? If so, please describe.
2. Do you have an injury or illness that may restrict your movement?
3. List any medications you are currently taking and why?
4. Have you ever been treated or hospitalized for alcoholism, drug addiction, depression, emotional problems or mental illness? If so, please describe.
5. Have you worked with a therapist in the past or are you currently in therapy? Was/is it a positive experience?
6. Is there anything else about your physical or emotional status we should be aware of?
7. Do you have any special dietary needs? (i.e. vegetarian, no wheat, etc.)? If yes, please describe.
8. Do you have a past history or currently experience any of the following?

<input type="checkbox"/> High Blood pressure	<input type="checkbox"/> Recent Surgery: _____	<input type="checkbox"/> Asthma
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Retinal detachment	<input type="checkbox"/> Stroke
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cancer	<input type="checkbox"/> Cardiovascular Disease
<input type="checkbox"/> HIV positive	<input type="checkbox"/> Allergies: _____	(including heart attacks)
<input type="checkbox"/> AIDS	<input type="checkbox"/> Are you currently pregnant?	
9. We sometimes share names and contact information of the participants with one another prior to the training date to schedule carpooling - are you okay with us sharing your name and information?
 Yes / No

Send your registration form with your food and lodging payment (checks made payable to Awakening Life) to:
Dan McKee PO Box 1378, Freeland, WA 98249

You may also e-mail your registration to danmckee@awakeninglife.org

If you wish to pay by credit card, include that information here or call Dan McKee at 503-754-7985 We accept MC, Visa, AMEX.
Credit Card: _____ Card Number: _____ Exp. date: _____
Name on the Card: _____ Billing address: _____

Questions? Contact Dan McKee at danmckee@awakeninglife.org or 503-754-7985