

APPLICATION & PSYCHOSOCIAL FORM
Eupsychia Institute's 10-Day Psychospiritual Healing Retreat
with Jacquelyn Small, LMSW and the Eupsychia Staff
(March 2007)

(Please Write Clearly or Type)

This application is for the following 10-Day Intensive:

_____ June 12-22, 2007
Center for New Beginnings
Dahlonega, Georgia

_____ October 2-12, 2007
Center for New Beginnings
Dahlonega, Georgia

Name of Applicant: _____

Street Address, City, State, Zip Code: _____

Telephone; Home: (_____) _____ Work: (_____) _____

Fax (____) _____ Email (important): _____

Gender: Male ___ Female ___ Are you a smoker? Yes ___ No ___

Diet: All meat OK ___ Vegetarian (Fish/Fowl OK) ___ Vegetarian (Strict) _____

Travel Information for the retreat: Are you flying? _____ or Driving _____?

Do you need shuttle service? Yes* ___ No ___ (*We will need your complete travel itinerary ASAP)

For rooming purposes, do you prefer to stay up late or to wake early? Late ___ Early ___

Date & Place of Birth: ___/___/_____, _____

Profession: _____

Marital Status: Married ___ Single ___ Divorced ___ Widowed ___
Co-Habiting ___ Remarried ___ Separated ___ Engaged ___

Name of Significant Other: _____

Address of Significant Other: _____

Telephone of Significant Other: (_____) _____

Children: Number _____ Ages _____

Physician's Name _____

Physician's Telephone _____

Have you attended previous Eupsychia events? Yes ____ No ____

How did you learn about this program?

- ____ Friend
- ____ Relative
- ____ Eupsychia Brochure Mailing
- ____ Eupsychia Website
- ____ Other website: _____
- ____ Ad in Magazine (Which?) _____
- ____ Other: _____

In case of emergency, who do we contact (must be completed):

Name: _____

Relationship: _____

Address: _____

City, State, Zip:

Phone(s): Home () _____ Work () _____

Do you have medical insurance? _____ If yes, what is your policy number? _____

Insurer's Name and Address:

Insurer's Phone Number: (_____) _____

(Confidential)
MEDICAL AND PSYCHOSOCIAL HISTORY

Statement of Confidentiality: The following information will be helpful to the Eupsychia staff in understanding your individual concerns. Please answer as accurately and truthfully as possible. The information obtained will be treated as privileged and confidential, and will not be released to any person without your written permission. This form and any copy will be destroyed within one year of your attendance at this program. Content is more important to us at Eupsychia than specific dates. When a date is not immediately remembered, an approximation is fine.

Though we prefer this form be filled out we can take this information by phone should you prefer not to have this information in written form.

Do you have any severe illnesses or injuries. If yes, please describe:

Are you on any medication now? List medication(s), dose, frequency, and reason:

Birth Complications (breach, c-section, etc.): _____

Were you adopted? Yes _____ No _____ If yes, at what age _____

••• MEDICAL HISTORY •••

How would you describe your current state of physical health?

Is there anything in your medical history or family health pattern that would be useful for us to know?

••• FAMILY HISTORY •••

MOTHER: Living _____ Deceased _____

If alive, describe your current relationship with her:

FATHER: Living _____ Deceased _____

If alive, describe your current relationship with him:

How would you describe the atmosphere in your home when you were a child?

Were you ever physically, mentally, emotionally and/or sexually abused as a child? Please explain _____

What role did you play in your family?

••• PSYCHOSOCIAL HISTORY •••

Have you ever had counseling or been in therapy? Please describe {for what reason(s) did you go, was your therapy helpful,...}

Have you ever been hospitalized for psychiatric problems? If so, when and why?

Are you alcohol or chemically dependent? Yes ____ No ____

If so, are you in recovery? Yes ____ No ____ If so, for how long? _____

Have you ever been in treatment for any addictive disorder? Yes ____ No ____

If yes, what was the disorder (alcohol, drugs, eating disorder, sex, etc.)

When were you in treatment? _____

Have you attended 12-Step meetings? Yes ____ No ____

Do you currently attend meetings? Yes ____ No ____

Would you like to participate in 12-Step meetings at this program? Yes ____ No ____

•••VOCATIONAL HISTORY•••

What is your occupation now? _____

Does your present work satisfy you? Yes ____ No ____

Please explain: _____

Education: _____

Other interests, hobbies and activities _____

••• MARITAL/SIGNIFICANT OTHER INFORMATION•••

If currently married or living with a primary mate, for how long?

Describe relationship problems or concerns you have or have had: _____

If applicable, describe any previous primary relationship you've had:

••• SEXUAL HISTORY •••

What problems/concerns do you have or have you had sexually?

Have you ever been raped/sexually abused or have you ever sexually abused someone else? If so, please describe.

••• SPIRITUAL HISTORY •••

Have you ever had a Near-Death Experience? If so describe circumstance and experience:

Have your spiritual views or internal spiritual experiences ever caused you trouble in the outer world?

Describe your religious or spiritual training and the role and meaning of spirituality in your life.

••• GOALS AND EXPECTATIONS •••

Please write briefly about what you expect of this Healing 10-Day Program.

If not covered above, what is there about your present behavior and/or feelings that you would like to change or provide any other information you feel it's important for us to know in understanding you:

Along with this Application/Psychosocial Form, please attach a recent photograph of yourself if you are flying into the Airport so we will recognize you.

Contraindications: Pregnancy, contagious diseases, severe heart conditions and severe cases of mental illness. We need to be informed of any conditions that require ongoing medical attention.

Signature

Date

Thank you. Please send your completed Application and Psychosocial History Form to us at the following address, fax or email:

**Eupsychia Institute, Attn: Healing Program, PO Box 151960, Austin, TX 78715
(800) 546-2795 • Fax (512) 327-6043 • eupsychia@austin.rr.com •
www.pathoftransformation.com**