REGISTRATION FORM

1.) Name: Beginning Date:

2.) Address:

Zip:

3.) Telephone Home: Work:

4.) Employed by:

5.) How did you hear about this class?

6.) Are you currently under the care of a physician or counselor for emotional difficulties?

a,) Name of physician or counselor:

b.) Address of physician or counselor

c.) Phone # of physician or counselor

7.) Are you currently taking any medications to tranquilize, sedate or alter mood?

(i.e. anti-depressants) What Medications?

8.) To your knowledge, do you have personal or family history of mental/emotional illness?

Who in your family?

9.) Have you ever contemplated or attempted suicide? When?

Were you treated for that depression?

How?

Facilitator's Copy