

**2008 INVITATIONAL THERAPEUTIC TOUCH WORKSHOPS
PATIENT APPLICATION**

The workshops are designed to teach Therapeutic Touch to health professionals and lay persons. Patients are accepted for the sessions indicated below. **Final decision on the healees' acceptance into the program will be at the discretion of Dr. Dolores Krieger. Application deadline: May 17, 2008**

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|---|---------------|----------|
| Therapeutic Touch Mentorship Program | (6/8 – 6/14) | \$530.00 |
| Continuing Explorations into TT Theory and Practice | (6/17 – 6/23) | \$530.00 |

Please see Healee Invitation for course description and additional information.

NAME: _____ **DATE OF BIRTH:** _____

ADDRESS (Street, City, State, Zip): _____

PHONE: _____ **SEX:** _____

E-Mail: _____

REFERRED BY: _____

Do you smoke? _____

EMERGENCY CONTACT: _____

RELATION TO YOU: _____

PHONE: _____ **CELL:** _____

Indicate 1st and 2nd choice. We will attempt to honor your choice; however final decision will be based on workshop needs.

_____ Therapeutic Touch Mentorship Program (June 8 - 14)

_____ Continuing Explorations into TT: Theory and Practice (June 17 - 23)

DEPOSIT: A \$75.00 (US funds) deposit is required. **REGISTER BY MAIL:** Send your check or credit card information, and your name and workshop, to the camp address: 360 Indralaya Rd, Eastsound, WA 98245. Include your name as it appears on your credit card, card number and expiration date. (We can take MasterCard and Visa.)

REGISTER ONLINE (NEW): Complete your registration at www.indralaya.com. A **secure site** is provided for credit card payment of the deposit.

DEADLINES: Must register by May 17th.

Office Use Only:

Date Received _____ Application
sent _____ Approved _____

Amount Paid _____ Session: Mentorship _____ Cont Exp

Patient Questionnaire

Name:

Date:

Please **bold** your answers:

1. Please give a brief medical history and a description of the condition to be treated:
2. What did the doctor call your condition?
3. List your specific symptoms, their severity, and how long you have experienced them.
4. Please indicate **ANY AILMENT OR PROBLEM CONDITION** that you have or had. Include any additional information or explanation that you think would be helpful to us.
5. Do you have any special requirements or restrictions (dietary, physical or other)? The kitchen will attempt to meet dietary needs within limits, but please inquire ahead of time if you have an unusually restricted diet.
- 6 List medications you are taking now - include dosage and frequency:
7. Have you had surgery within the last 5 years, or are you considering surgery in the immediate future?
If yes, please describe.
8. Please describe any alternative (complementary) treatments or strategies you have used and their outcomes.
9. How do you think Therapeutic Touch might benefit your condition?
10. Do you self-prescribe periods of rest, and if so please describe.
11. Please include any additional information you believe would be helpful to us.