Breathwork Intake Form

Elemental Rhythm Client Information and Consent

ELEMENTAL RHYTHM

Name

DOB   Occupation

Phone   Zip

City   Email

Client
Intention

Breath Assessment

GOOD BREATHING HABITS	Yes	No		Yes	No
Nasal breathing	◯	◯	Good posture	◯	◯
Mouth closed when speaking	◯	◯	Relaxed breathing	◯	◯
Rhythmic Regular Breathing	◯	◯	Deep breathing	◯	◯
			Slow breathing	◯	◯

POOR BREATHING HABITS	Yes	No		Yes	No
Mouth Breathing	◯	◯	Noisy Breathing	◯	◯
Mouth open most of the time	◯	◯	Tense Shoulders	◯	◯
Fast breathing	◯	◯	Poor Posture	◯	◯
Shallow Breathing	◯	◯	Short focused exhalation	◯	◯
Chest Breathing	◯	◯	Upper chest move	◯	◯
Lots of yawns and sighs	◯	◯	Anxious/Poor Focus	◯	◯
Irregular Breathing	◯	◯	Tapping/Twitching/Nervous	◯	◯

Do you want to focus on Breathwork Fundamentals? Mindwork coaching? Mix of both?

_____

Health Assessment

CP/CO2 Score: _____   Resting Heart Rate: _____

Self Sleep Score 1-10: _____   Any other Biomarkers you Use? HRV, Blood Sugar
ETC?

Max Hold(in): _____   _____

What are you wanting to transform or heal?

What do they want to achieve?

If they could see a shift in 90 days, how would they want to feel?

What do they want to be able to do that they struggle with now?

CLIENT OBJECTIVES: _____

_____

_____

_____

_____

AS THEY REFLECT ON THE SEVEN AREAS OF LIFE. WHICH CAME UP FOR THEM?

Mental - Life / Growth / Learning / Expansion
Emotional
Health / Physical / Diet
Relationships / Family / Friends / Career
Career / Business
Financial / Abundance
Consciousness / Spirituality Life Purpose

Do they understand how breath impacts the nervous system?

Life Story (History and Current Situation):

Have they completed the Creative Visioning Process Y or N

CORE WOUNDS

_____

_____

_____

UNMET NEEDS

_____

_____

_____