

# The Hoffman Process Enrolment Form

In order for us to confirm your place on the Process, we ask that you complete all the information on this form and return it either by post to the address at the end or scan it to [enrolment@hoffmaninstitute.co.uk](mailto:enrolment@hoffmaninstitute.co.uk) as soon as possible.

## Personal Information

Name: \_\_\_\_\_ Process date: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
Gender: \_\_\_\_\_ Nationality: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Company/Position: \_\_\_\_\_  
Address: \_\_\_\_\_  
Mobile No: \_\_\_\_\_  (tick preferred number)  
Home Tel: \_\_\_\_\_   
Email: \_\_\_\_\_ Skype: \_\_\_\_\_  
How/from whom did you first learn about the Hoffman Process? (Please specify name)  
\_\_\_\_\_

## Arrival and Accommodation

You are registered for a Process at **Florence House**, Southdown Road, Seaford, E. Sussex, BN25 4JS.  
Contact details for Florence House: 01323 873 700, [info@florencehouse.co.uk](mailto:info@florencehouse.co.uk), [www.florencehouse.co.uk](http://www.florencehouse.co.uk)

**Registration is on Saturday between 9 and 9.30am. The course finishes at 2pm the following Friday.**

*If you wish to arrive earlier, you may stay on the Friday night. Please arrive between 4 pm and 10pm.  
There is an additional charge for Friday night: Bed and Breakfast = £50. With Dinner = £17.50 Total £67.50  
If you are delayed or your plans change, please contact Florence House to avoid incurring a charge.*

I will arrive on Friday  I would like Dinner (Dinner is served at 7pm) Yes  No   
I will arrive on Saturday

Accommodation is shared with 1-2 other people of the same gender. Do you snore? Yes  No

## Dietary Requirements

Florence House provides nutritious, wholesome food throughout the week. We do not recommend that you use the week to detox or change your diet.

Are you vegetarian? Yes  No  Do you eat fish? Yes  No  Do you eat pork? Yes  No

Florence House will cater for the following diets by special arrangement at an extra charge of £55 per week.

Vegan  Gluten free  Wheat free  Dairy free  Lactose free

Please specify allergies or other dietary information: \_\_\_\_\_

**Please call Florence House in advance to pay for additional accommodation and special diets.**

## Emergency Contact Information

1. Please provide contact details of one person who knows you are participating in the Process.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Tel: \_\_\_\_\_

2. Please provide an additional contact.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Tel: \_\_\_\_\_

<b>Office Use only:</b> Contact Details Checked? _____ History Checked? _____ GP Guidelines: Needed <input type="checkbox"/> Sent <input type="checkbox"/> Therapist Guidelines: Needed <input type="checkbox"/> Sent <input type="checkbox"/>
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**YOUR APPLICATION TO PARTICIPATE IN THE HOFFMAN PROCESS:**

We realise that the questions on this form may bring up sensitive issues, and we ask you to please answer as honestly as possible. Your application is confidential and your answers will help us to assess whether there is any reason why you should *not* participate in the Process for your own well-being. It is not possible for us to predict any participant’s experience, or the effect of the Process on them, but if we feel that for any reason it is not appropriate for you to attend, we will try to recommend an alternative course or treatment. Your deposit would be refunded to you at that point. The Hoffman Institute must approve this enrolment form to confirm your place on the Hoffman Process.

In some cases we may require that you contact a Doctor or Therapist before you participate in the Process.

Please ensure that you have read and fully understand and agree to our Terms & Conditions (found with your registration documents) as they contain information about our cancellation policies. Please note that you will be required to sign a Declaration & Consent Agreement on the day of your arrival.

It is a condition of your participation that you notify us before starting the course if there are any changes to the information you have provided.

If you have any questions please contact the office on: 01903 88 99 90

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**Your submission of this form confirms that you understand and agree to be legally bound by these terms and also agree that the information given is true and accurate.**

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**Confidential Health Information**

1. Has a Doctor or other practitioner ever treated you for, or told you that you have:

Please answer Yes or No	Yes	No		Yes	No
Tumour/Growth/Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Dizzy spells	<input type="checkbox"/>	<input type="checkbox"/>
Liver trouble	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Loss of consciousness	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Brain concussion	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Severe/frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>
Heart trouble/murmur	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Low/High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Joint or muscular disorder	<input type="checkbox"/>	<input type="checkbox"/>
Any digestive tract disorder	<input type="checkbox"/>	<input type="checkbox"/>	Loss of hearing	<input type="checkbox"/>	<input type="checkbox"/>
Gallbladder disease	<input type="checkbox"/>	<input type="checkbox"/>	Vision impairment	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disorder	<input type="checkbox"/>	<input type="checkbox"/>	An infectious disease	<input type="checkbox"/>	<input type="checkbox"/>

If you answered yes to any of the above, please can you provide us with more information, including dates and treatment received: \_\_\_\_\_

\_\_\_\_\_

2. Have you ever had any significant injuries, diseases or surgery?..... Yes  No

If yes, please provide more information: \_\_\_\_\_

\_\_\_\_\_

3. Do you have any reason to believe that you are not in good health? ..... Yes  No

If yes, please provide more information: \_\_\_\_\_

\_\_\_\_\_

4. This course involves some vigorous bodily movement and physical activity.

Do you have any physical limitations that might affect your ability to participate? ..... Yes  No

If yes, please provide more information: \_\_\_\_\_

\_\_\_\_\_

5. Do you have any physical issues that are aggravated by emotional stress? ..... Yes  No   
If yes, please provide more information: \_\_\_\_\_

6. Are you taking any prescribed medication for any of the above? ..... Yes  No   
Name(s) of medication(s) and how long have you been taking it? \_\_\_\_\_

7. How many hours of sleep do you normally get? \_\_\_\_\_

8. Have you ever suffered from insomnia/sleep disorder? ..... Yes  No   
If yes, please provide more information: \_\_\_\_\_

9. Are you on any sleep medication, prescribed or otherwise? ..... Yes  No   
If yes, please provide more information: \_\_\_\_\_

10. Do you have a reading or learning disability? ..... Yes  No   
If yes, please provide more information: \_\_\_\_\_

11. Are you pregnant? ..... Yes  No   
If yes, how many weeks and is it your first pregnancy? \_\_\_\_\_

*If you are pregnant we will require you to consult with your doctor and contact the office before we accept you on the Hoffman Process. If you become pregnant between completing this application and attending the course, you must consult your doctor about attending and confirm this with us.*

12. Do you drink alcohol? ..... Yes  No   
If yes, how much? \_\_\_\_\_ How often? \_\_\_\_\_

13. Do you use recreational drugs? ..... Yes  No   
If yes, which drugs? \_\_\_\_\_ How often? \_\_\_\_\_

*In order to gain the most from the course, we ask that you refrain from alcohol and any substances which may affect your concentration or ability to access your feelings, for at least two weeks before the course starts and throughout the duration of the course. For your own safety and the safety of others it is a requirement of the Hoffman Institute that you do not bring alcohol or recreational drugs to the Process venue. If you breach or break this agreement you will be asked to leave the Process and premises.*

14. Do you have, or have you ever had an eating disorder? ..... Yes  No   
If yes, please provide details including dates: \_\_\_\_\_

15. Are you in a recovery programme for any of the above? ..... Yes  No   
Name of recovery programme(s): \_\_\_\_\_  
How long have you been in recovery? \_\_\_\_\_

**Doctor**

Please provide the name of your Doctor in case of emergency:

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Address: \_\_\_\_\_ Email: \_\_\_\_\_

We have guidelines about the Hoffman Process that we send out to health professionals. Would you like us to send some to your doctor? **Yes please**

**Emotional Wellbeing**

16. Are you currently in therapy? ..... Yes  No

When did you start going and what type of therapy is it?

How often do you see your therapist? \_\_\_\_\_

What issues are you seeing your therapist for and how are you benefiting? \_\_\_\_\_  
\_\_\_\_\_

**Please provide details of your therapist. We will not speak to them without your permission.**

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_

It is standard practice to send Process guidelines to your therapist. The information will also help your therapist support you before and after the Process. Please tick this box if you would **NOT** like us to send guidelines to your Therapist

17. Have you been in therapy in the past? ..... Yes  No

When and how often did you go? \_\_\_\_\_

What kind of therapy was it? \_\_\_\_\_

What issues were you seeing your therapist for and how did you benefit? \_\_\_\_\_

18. Have you ever been diagnosed with a psychological condition or psychiatric illness?.....Yes  No

Please provide more information including dates, who it was diagnosed by and treatment

\_\_\_\_\_  
\_\_\_\_\_

19. Have you ever been hospitalised for a mental disorder? .....Yes  No

Please provide more information including dates, diagnosis and treatment

\_\_\_\_\_  
\_\_\_\_\_

20. Have you ever had a 'nervous breakdown'?.....Yes  No

Please provide more information including dates, diagnosis and treatment

\_\_\_\_\_  
\_\_\_\_\_

21. Have you ever suffered from or been treated for PTSD or any other traumatic response?...Yes  No

Please provide more information including dates, diagnosis and treatment

\_\_\_\_\_  
\_\_\_\_\_

What professional support have you received?

\_\_\_\_\_  
\_\_\_\_\_

22. Are you currently taking any prescribed medication, which is commonly used for emotional illness, anxiety or depression? ..... Yes  No   
Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

23. Have you previously taken such medication? ..... Yes  No   
Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

24. Did either of your parents or surrogate parents suffer from a major psychiatric disorder during your childhood? (e.g. Schizophrenia, Bipolar Disorder/Manic Depression, Major Depressive Disorder, Psychosis or Personality Disorder) ..... Yes  No   
Please provide details: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

25. Have you experienced bereavement within the last 12 months? If so, please give details... Yes  No   
Relationship to person: \_\_\_\_\_ Date: \_\_\_\_\_

26. Have you ever attempted suicide? ..... Yes  No   
If so, at what age: \_\_\_\_\_  
Circumstances: \_\_\_\_\_

27. Did you experience physical abuse as a child? ..... Yes  No   
If so, at what age: \_\_\_\_\_ Circumstances: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

28. Have you ever experienced sexual abuse? ..... Yes  No   
If so, at what age: \_\_\_\_\_ Circumstances: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

29. If you answered 'yes' for any of questions 25 – 28, what professional support have you received?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

30. What would you say are your current main sources of stress? For example, current relationship/family problems, separation, divorce, work stress, illness, bereavement, addictions, major life changes.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

31. What do you consider to be the most traumatic or distressing event in your life and when did it occur?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

32. What do you hope to gain from your week on the Hoffman Process?

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**Please confirm that you have read our Terms and Conditions by ticking the box:**

<http://www.hoffmaninstitute.co.uk/booking-terms-and-conditions/>

**Next Steps**

If you have not already spoken with one of the enrolment team, we will be in touch to arrange a convenient time to discuss the Process further.

Six weeks before the start of your course we will email you the pre-course work. This work is designed to teach you the essential concepts of the Hoffman Process and your responses will form much of the content of the first days of the course. We ask you to complete it comprehensively and with careful attention to each section. Your course work must be returned to the Hoffman Institute *at least 2 weeks* before the start of your course in order that one of the Hoffman teaching team has time to read it before arranging to speak with you.

*Thank you for completing this form. Please remember to save a copy with your name and email it back to the office as soon as you can.*

**Please return this completed form to:** enrolment@hoffmaninstitute.co.uk

The Hoffman Institute, P.O Box 72, Quay House, Arundel, West Sussex BN18 9DF  
Tel: +44 (0) 1903 88 99 90