

# Ayahuasca Awakening

## Participant Questionnaire

Full Name :

Date of Birth:

Age :

Gender:

Gender Pronouns:

Address:

Email :

Home Phone :

Cell Phone:

Preferred Method of Contact:

How did you find out about the Ayahuasca Awakening?

Emergency Contact Name:

Emergency Contact Phone:

Are you currently taking any medications? If so, please list all medications.

Have you ever been diagnosed with any medical, physical or psychological conditions? If so, please list the condition.

Have you ever had any of the following conditions? Please check all that apply.

Heart Problems

Psychosis

High Blood Pressure

Bipolar

Stroke

Schizophrenia

Epilepsy

Seizures

Are you taking any of the following medications, drugs or supplements? Please check all that apply.

- MAOI Inhibitors
- Other MAOIs
- SSRI's (any selective serotonin reuptake inhibitor)
- Antihypertensives (high blood pressure medicine)
- Appetite suppressants (diet pills)
- Central Nervous System Depressants (Examples: Xanax, Ativan, etc.)
- Vasodilators
- Antipsychotics
- Barbiturates
- Cocaine
- Amphetamines (meth-, dex-, amphetamine)
- Ephedrine, MDMA (Ecstasy), MDA, MDEA, PMA
- Opiates (heroin, morphine, codeine, and especially opium)
- Dextromethorphan (DXM)
- Mescaline (any phenethylamine)
- St. John's Wort
- 5-HTP

Are you pregnant or is there any change that you may be pregnant?

I HEREBY CERTIFY that I have answered the Participant Questionnaire truthfully and completely and am free from any known or unknown heart, physical, mental, drug or any other health problems that could prevent me from participating or cause complications during my participation. I agree that my safety is primarily dependent upon taking proper care of myself during the Ayahuasca retreat /ceremony, and in following all pre and post Ayahuasca ceremony / retreat, dietary and health guidelines, including abstaining from medications and drugs. I certify that I will consult with my health care provider before ceasing any medications or medical treatments, and I will consult with my health care provider if I suspect that I may have any conditions that could make participating in the Ayahuasca retreat/ceremony unsafe.

\*\*\*I will notify Ad Astra Awakening immediately if any of the aforementioned information in my Participant Questionnaire changes.\*\*\*

Signature

Name:

Date: