



# Art of Living DSN COURSE

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First Name

Last Name

Address

City

Home phone

Cell phone

Email

Occupation

Date of birth

Sex: Male\_\_\_ Female\_\_\_

How did you find out about this course?

If you are presently under the care of a physician, or psychiatrist, or have been recently hospitalized, please describe:

Please list any long-standing health problems or recent health concerns

Asthma and breathing problems

High blood pressure

Epilepsy

Migraine

Pregnancy

Heart disease

Other:

Please describe in detail any medications you are taking

Please list any meditation techniques or other self-development courses/techniques you have done:

Date

Course/Technique

Experiences and/or Results

**It is compulsory to attend all sessions of the course. Taking notes and use of tape recorders is prohibited.**

**Agreement:** *I understand that any benefits derived from this course depend upon the extent of my participation. I therefore accept full responsibility for the outcome and I willingly agree to follow all instructions and participate fully. I also agree that I will not disclose the content of this course to anyone. I further agree that I will not attempt to instruct others in any of the techniques used in the course.*

Signature \_\_\_\_\_ Date \_\_\_\_\_

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**Financial - For Office Use Only**

**Course Fee:** \_\_\_\_\_

**Money Received:** YES

NO