Application Questions for Using Mindfulness Based Stress Reduction to Improve Medical Outcomes

FULL NAME ___________________________________________________  BIRTH DATE ______________  GENDER ________

FIRST MI LAST

SS# _____________________    ADDRESS _________________________________________________________________
STREET/APT       CITY       STATE             ZIP CODE

HOME PHONE__________________   CELL PHONE____________________   EMAIL _______________________________

*is it okay to call or leave a message at home?    ☐ Yes    ☐ No  *is it okay to send email?    ☐ Yes    ☐ No
*is it okay to call or leave a message on your cell? ☐ Yes    ☐ No  *is it okay to send text message?  ☐ Yes    ☐ No

What do you hope to accomplish by joining this group?
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

What medical diagnoses do you currently have?
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

What mental health diagnoses do you currently have?
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

What medications are you on?

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<th>Name</th>
<th>Prescriber</th>
<th>Condition</th>
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Who are your medical and/or mental health providers?

Name: ______________________ Specialty: ______________ Contact: ______________________

Name: ______________________ Specialty: ______________ Contact: ______________________

Name: ______________________ Specialty: ______________ Contact: ______________________

Other: ___________________________________________ ____________________________

What treatments have you tried to manage your current health conditions?

______________________________________________________________

Do you know if you are able to sit for long periods of time and do yoga poses?  

☐ Yes  ☐ No  ☐ Unsure, ______________

Have you had any suicidal ideation or thoughts of self harm in the past 3 months?  

☐ Yes  ☐ No

Do you have a history of suicidal ideation or self harm?  

☐ Yes  ☐ No

Are you using drugs or alcohol currently?  

☐ Yes  ☐ No

If you answered yes, please complete the following.

Substance: __________________________ Amount: ______________ Frequency: ______________

Substance: __________________________ Amount: ______________ Frequency: ______________

Client Agreement

☐ I understand that this group is designed to add to my current medical and mental health care, not replace my current services.

☐ I agree to do the homework assignments to the best of my ability, recognizing that they are essential to progress.

☐ I agree to consult with my doctors regarding what yoga poses I can do safely.

☐ I agree to follow directions of my doctors and therapist regarding what I can and cannot safely do of the group curriculum.

☐ I agree to inform the group lead of any limitations I have regarding sitting for long periods or doing yoga poses.

☐ I agree to hold other group members names and information confidential.

☐ I agree to attend all sessions to the best of my ability.

_____________________________     ___________________  
Client Name                      Client Signature                        Date  

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