Mindfulness Based Stress Reduction Client Form
CONFIDENTIAL

Name___________________________________ DOB__________________ Gender ___

Address____

Day Phone_______________________________ Evening Phone___________________

Do you give permission to be contacted at the phone numbers provided?_______

Email____

Preferred means of contact____

Emergency Contact Name/ Relationship______________________________________

Emergency Contact Phone____

Your Occupation/ Employer____

Who are the important people in your life (spouse/partner, children, friends, family, co-workers, etc.)____

____

____

Sleep Quality_____________________________ Weight____________ Height_________

Do you smoke? __________________________ Caffeinated drinks per day_________

How often do you exercise each week? ___ Do you eat a balanced diet? ________

Special Dietary Choices/Needs____

Do you take any prescription medications (Please list) _________________________

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Do you use drugs or alcohol? _________ If so, how much?_____________________

History of substance abuse (if relevant)_____________________________________

____

Previous overnight hospitalizations (Include Year)

Medical/Surgical____

Psychological/Psychiatric____

What is your main reason for participating in the Mindfulness Based Stress Reduction (MBSR) Program? ____

____

What are the most significant stressors in your life right now? __________________

____

Do you have any past experience with meditation or yoga? ____________________

How did you find out about the MBSR program at Full Spectrum Wellness? ______

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