***Mindfulness Based Stress Reduction Program Orientation Paperwork***

**Thank you for filling out these forms. We realize the personal nature of these questions. Please be assured that your information is kept in strict confidence,**

**and is used solely to help your instructor better address your concerns.**

First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

City, State, Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

How did you hear about the program?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any experience with meditation? If yes, please describe. Also,

Share whether you have experienced anything unusual while meditating.

Why are you interested in taking this class?

Are you currently in physical pain in your body? If yes, please describe. Are you

under the care of a doctor about this?

Do you have trouble sleeping?\_\_\_\_\_\_ Do you take any medication for this?

Do you suffer from depression, anxiety or post-traumatic stress?

If yes, please explain whether the problem is chronic, whether you feel you are currently experiencing the problem and what you are doing to cope?

Are you currently seeing a therapist?

Are you currently taking any psychiatric medication? If yes, please describe. Is this prescribed by your primary doctor or are you currently under the care of a psychiatrist?

Have you ever tried to end your life? If yes, when and was it more than one time?

Have you ever been hospitalized for psychiatric reasons? If yes, when?

Previous hospitalizations in the last year for medical/surgical reasons?

Do you currently use drugs or alcohol? If so, how much? Have you ever been in

treatment? If yes, please explain.

Given what you know about the time commitment do you feel you can commit to the regularity of practice? And that you can commit to coming to every session and the retreat?

Is there anything else you would like us to know?

**Please make sure you bring a yoga mat, a blanket in case it gets cold and a pillow for comfort during lying down meditation.**

***Note:*** *Upon receipt of your paperwork, I will contact you to schedule a phone conversation to review the enrollment form prior to the orientation. Thank you!*

**\*PLEASE SIGN CONSENT FORM ON LAST PAGE**

**MBSR Informed Consent**

I understand that I am agreeing to participate in the Mindfulness Based Stress Reduction Program, which carries with it the potential of positive benefits and/or unpleasant feelings. The risks, benefits and possible side effects of the MBSR Program have been explained to me. The MBSR Program includes skills training in relaxation and meditation methods as well as gentle stretching (yoga) exercises. I am aware that during the course I will be asked to practice these as appropriate for my ability. I understand that this course is designed to help me appropriately learn skills and to never push beyond my capabilities. I understand that if for any reason I am unable, or think it unwise, to engage in these techniques and exercises either during the weekly classes or at home, I am under no obligation to engage in these techniques, nor will I hold Integris Baptist Medical Center, Integris Cancer Institute, or the instructor, Marnie Kennedy, liable for any injuries incurred from these exercises. I agree to practice self-care while participating in the group, and when needed, I will slow down, take a breath/or take a break and step away.

This course is in no way a substitute for medical care or psychotherapy. If I am currently in treatment for a medical or psychiatric condition, I have consulted with my physician and/or therapist about my ability to participate in this program. I have obtained their agreement to enter the program and their willingness to consult with me as appropriate for the duration of the program. If appropriate, I have provided the MBSR teacher with all relevant information about my medical and psychotherapeutic care.

**Email communication**

As a participant in the MBSR Program you may wish to communicate with your instructor via email on occasion. In order to ensure your privacy appropriate to your intentions, we request that you give written permission for this form of correspondence as appropriate.

Please check the appropriate box below:

\_\_\_\_\_I give permission to communicate via email with my instructor about any aspect of my MBSR Program. My email address: (Print Clearly)

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

\_\_\_\_\_I DO NOT give my permission to communicate via email

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 Signature Date