Reviewed by _____
For staff use only: Year:
- Circle one: Fall Winter Spring Summer Yes/No/Postpone

LVHN Center for Mindfulness

Orientation Series

Intake Form (R2)

We realize the personal nature of the following questions and appreciate your time in completing these forms. Please note that the purpose in asking these questions is to help us make the best decision about what program would be most helpful to you, as well as how to best help you have a positive result from taking the MBSR program. Also, please be assured that the information is kept in strict confidence and remains in our office only.

Today's Date: _____

Name: _____ Date of Birth: _____

Address: _____
Street

_____/_____/_____
City State Zip

Telephone: ( ) _____ ( ) _____
Home Work

E-mail address: _____

May we use your contact information to send you program announcements from the LVHN Center for Mindfulness? Yes_____ No _____

How did you hear about the program?
- _____ website
- _____ flyer/brochure
- _____ newsletter
- _____ friend (if so, who?_____)
- _____ healthcare professional (if so, see next question)

If a Healthcare Professional (physician, therapist, nurse, etc.) referred you, please provide his/her contact information below:

_____
Healthcare Professional Who Referred You

_____
Address

_____
Phone No.

Medical Information

Please indicate your current conditions, symptoms and medications (prescription, over-the-counter, herbs or vitamins)

Condition	**Y**	**Symptoms** Mild (1) Moderate (2) Severe (3)	**Symptoms** Continuous or Episodic?	**Current Medicines**
Anxiety				
Arthritis				
Cancer—Current				
Cancer—Past				
Depression				
Diabetes				
Fibromyalgia				
Gastro-intestinal				
Heart disease				
Hypertension				
Sleep problems				
Musculo-skeletal:				
Neurologic disorder (eg. Headache)				
Other: (List)				

Do you experience **chronic pain**? (Pain for 3 months or longer) ☐ Yes ☐ No

If yes, how long have you been in chronic physical pain? _____

What part(s) of your body is (are) in chronic pain? _____

Do you have any physical limitations that challenge your movement or sitting for long periods of time? ☐ Yes ☐ No
Please describe if yes: _____

Have you experienced a **significant loss** recently? ☐ Yes ☐ No

If yes, please explain:

_____

Have you ever experienced what you would describe as **acute or chronic trauma**? (This might include a history of childhood abuse, being the victim of violence, engaging in active warfare, or another event). Yes_____ No_____

Have you ever required psychiatric hospitalization? ☐ Yes ☐ No

Have you ever been under the care of a psychiatrist? ☐ Yes ☐ No

Are you *currently* under the care of a psychiatrist or a psychotherapist? ☐ Yes ☐ No

If yes, please indicate his/her name, location, and how long you have been working together:

_____

_____

Are you using any mind-altering substances (alcohol, drugs, etc.) that may influence your ability to practice meditation? ☐ Yes ☐ No

If yes, please explain.

_____

_____

How do you currently manage stress/stressful situations?_____

_____

Have you ever meditated before? ☐ Yes ☐ No

If yes, what type of meditation and how many months/years did you practice?

_____

_____

Are you currently meditating regularly? ☐ Yes ☐ No

If yes, how frequently and what type of meditation practice?

_____

_____

_____

Have you experienced anything unusual while meditating? ☐ Yes ☐ No

If yes, please explain.

Please describe what you hope to achieve in taking the Mindfulness Based Stress Reduction:

1)

2)

3)

Please bring this completed form to your scheduled orientation meeting. Thank you!

Reviewed by:_____ Date:_____ (staff use only)