Mindfulness-Based Stress Reduction Program (MBSR)
University of Arkansas for Medical Sciences
Mindfulness Program

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

Name: _____

E-Mail: _____

Telephone# Home ( ) _____

Work ( ) _____

Cell ( ) _____

(Please indicate best tel. # to leave you a message)

Please mail the completed forms to:

UAMS Mindfulness Program
ATTN: MBSR Course
4301 W. Markham Street, Mail Slot #789
Little Rock, AR 72205

If you prefer, you can scan and email the Form to: FBYu@uams.edu

1. What is your main reason for participating in the MBSR Program?

_____

_____

2. Occupation: _____

3. Date of Birth: (MM/DD/YEAR)_____/___/_____

4. Family Information: (please circle)
Single - Married Not Married Living with Partner Separated Divorced Widowed

5. Do you have children? (Yes/No) _____
5a. If so, how many?_____5b. Ages?_____

6. Do you have close friends? (Yes/No) _____

7. Sleep quality: _____

8. Do you smoke?_____

9 . Caffeinated drinks per day: _____

10. Do you exercise? _____

11. Do you use drugs or alcohol? _____How much? _____

12. Do you have a history of substance abuse? _____

_____

13. Do you take prescription medications? (Please list):_____

_____

_____

14. Are you currently engaged in psychotherapy?

_____

15. If no, have you been in therapy during the last three years?

_____

16. Previous overnight hospitalizations? (Year)

Medical/Surgical

_____

Psychological

_____

During the last MONTH have you:

a. Considered suicide?	YES	NO
b. Sought psychiatric help?	YES	NO
c. Had thoughts of death or dying?	YES	NO
d. Had urges to beat, injure or harm someone?	YES	NO
e. Had urges to smash or break things?	YES	NO
f. Had spells of terror or panic?	YES	NO

Please take a moment as you respond to the following three questions.

17. What do you care about most?

_____

18. What gives you the most pleasure in your life?

_____

19. What are your greatest worries?

_____

Appendix B: How did you learn about this program?

Date: _____

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We are interested in knowing how you learned about our program. Would you help us by checking off any and all the ways you first learned about the Mindfulness-Based Stress Reduction Program?

_____ Primary Care Physician

Physician's first and Last Name_____

_____ Other Health Care Provider

_____ Specialty Physician

_____ Psychologist/Social worker/Psychotherapist

_____ Primary Care Nurse Practitioner

Other Health Care Provider's First and Last Name _____

_____ I received an appointment reminder with information regarding the Mindfulness-Based Stress Reduction Program

_____ Jon Kabat-Zinn's Book

_____ Saki Santorelli's Book

_____ Friend/Relative that took the class

_____ Television

_____ Article from _____

_____ Google Ad

_____ Other (please describe):_____

Appendix C: Personal Goals

Please list three personal goals you have for taking the Mindfulness-Based Stress Reduction Program:

1)

_____
_____
_____

2)

_____
_____
_____

3)

_____
_____
_____

Appendix D: Informed Consent

Mindfulness-Based Stress Reduction Program
University of Arkansas for Medical Sciences Mindfulness Program

Informed Consent Agreement

The risks, benefits and possible side effects of the Mindfulness-Based Stress Reduction Program were explained to me. This includes skill training in meditation methods as well as gentle stretching (yoga) exercises. I understand that if for any reason I am unable to, or think it unwise to engage in these techniques and exercises either during the weekly sessions at UAMS or at home, I am under no obligation to engage in these techniques nor will I hold the above named facility liable for any injury incurred from these exercises.

Furthermore, I understand that I am expected to attend each of the eight (8) weekly sessions, the daylong session and to practice the home assignments for 40-60 minutes per day during the duration of the training program.

_____ _____

Date Please Print Name

_____

Participant's Signature

_____

Parent or Legal Guardian
(If a Minor)

EMAIL COMMUNICATION CONSENT

As a participant in the Mindfulness-Based Stress Reduction Program, you may wish to communicate with your instructor via email on occasion. In order to ensure your privacy, we request that you give written permission for this form of correspondence.

Please complete the form below and check one of the following options:

___I give my permission to communicate via email with my program instructor about any aspect of my Mindfulness-Based Stress Reduction Program experience.

___I DO NOT give permission to communicate via email.

Signature:_____ Date: _____

University of Arkansas for Medical Sciences Mindfulness Program

Acknowledgment and Waiver of Liability

I accept full responsibility for my health and voluntarily complete this Acknowledgementand Waiver of Liability. I understand and agree that the services and tools offered in the University of Arkansas for Medical Sciences Mindfulness Program offered by the teachers of the University of Arkansas for Medical Sciences Mindfulness, its officers, employees and agents are not intended to replace or be substituted for medical or psychiatric care. It is recognized that the trainings inherent in the programs may at times make participants feel vulnerable. Mindfulness programs are not therapeutic interventions for psycho-pathological disorders as defined in the DSM and are not intended as such. By completing this release and consent I assume all risk for any physical or mental consequences of participating in the program. By signing this release I also specifically and expressly agree to hold harmless, indemnify and release the teachers of the University of Arkansas for Medical Sciences Mindfulness Program, its officers, employees and agents from any and all liability for the results of the educational guidance that will be or have been provided. Moreover, I acknowledge that the particulars shared in these classes by other participants are to be maintained as confidential. I will not blog or otherwise report on content shared in these classes in any form of media.

_____
Print - Full Name of Participant

_____
Signature of Participant

_____
Date