WESTSIDE WELLNESS
CHIROPRACTIC

MBSR INTAKE FORM

We realize the personal nature of the following questions and appreciate your time in completing this form. Please be assured that the information is kept in strict confidence and remains in our office only.

Today's Date:

Name:

Address:

Telephone:

Email:

Age:

Gender:

Preferred Pronoun:

Marital Status:

Number of Children and Ages:

Do you have chronic physical pain? (pain for 3 months or longer?)

If yes, how long have you had chronic pain?

What parts of your body are in chronic pain?

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Have you experienced a significant loss recently?
If yes, please explain

Have you ever required hospitalization under the care of a psychiatrist or other mental health provider?

Are you currently under the care of psychiatrist or psychotherapist or counselor?
If yes, please indicate their name, location, and how long you have been working together:

Please Note:

We would like you to review your participation in the MBSR Program with your psychiatrist/psychotherapist to ensure that it is consistent with the goals of your therapy. Do we have permission to contact your therapist? If yes, please sign below:

I, _____ give permission for the staff of Westside Wellness MBSR program contact my psychotherapist/psychiatrist.
Signature: _____

Current Work Status/Occupation:

What are your current sources of stress?

How do you currently manage stress/stressful situations?

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Are you using any mind-altering substances (alcohol, drugs, etc.) that may influence your ability to practice meditation? If yes, please explain.

Have you ever mediated before?
If yes, what type of mediation and how many months/years did you practice?

Are you currently meditating regularly?
If yes, how frequently and what type of mediation practice?

Have you experienced anything unusual while meditating?
If yes, please explain:

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