



Mindfulness-Based Eating Program

Registration Form

Thank you for filling out these forms. We realize the personal nature of these questions. Please know that the completed forms are kept in strictest confidence.

Name:	
Address:	
City	Postal Code
E-Mail Address:	
Home Telephone:	Work Telephone:
Referral Source: (please check all that apply) <input type="checkbox"/> Physician <input type="checkbox"/> Health Care Practitioner <input type="checkbox"/> Previous Class Member	<input type="checkbox"/> Newspaper <input type="checkbox"/> Mindfulness-Based Program Brochure <input type="checkbox"/> Other
Age: (used only for demographic research information.)	

Please return completed registration forms along with a non-refundable deposit of \$100 if you have not already paid for the program. Please make check payable to *Centre for Mindful Therapies*. If you wish to pay by Visa, kindly contact the office. The balance of \$350.50 is due at the first class. Return all completed forms and \$100 deposit to the address below. Please note that if we do not have sufficient registration for one of the program times, we will accommodate those who have registered in another session. If the time is not convenient, we will return your deposit or payment.

If you require more information, please contact me and I will be happy to provide it to you.

Regards,

Anne Dranitsaris, Ph.D.

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Name: _____

Date: _____

1. Please describe what you consider to be stressful in your life, i.e. job, relationships, a chronic or life threatening illness, etc.

2. What are your greatest worries and stresses?

3. Describe your typical eating behaviours.

4. Are you aware of particular situations or feelings that trigger these eating behaviors? If so, please describe

5. Please rate your overall stress level at this point in your life using a 1 – 10 point scale.
“1” = stress free, and “10” = stressed to the max. Mark an “X” at the appropriate area on the line below.
“1” _____ “10”

6. Please describe any previous experience you have had with eating programs, stress reduction, meditation, relaxation, mindfulness, imagery, and other mind-body approaches to healing and health. If you have not had any prior experience, please write “no experience.”

7. What target goals would you like to set for yourself in taking this program?
8. What do you care about most in your life?
9. What gives you pleasure? What do you enjoy?
10. Please list any previous hospitalizations with dates.
11. Please describe any complementary or alternative treatments you have received or are receiving.
12. Please describe your physical health right now.
13. Please describe your emotional health. What are your biggest emotional challenges?
14. Indicate whether you have been or are exposed/use the following (and if so, how much): <input type="checkbox"/> tobacco smoke <input type="checkbox"/> coffee <input type="checkbox"/> tea <input type="checkbox"/> pop <input type="checkbox"/> alcohol <input type="checkbox"/> recreational drugs <input type="checkbox"/> excess stress <input type="checkbox"/> chemicals
15. Please describe your support system.

16. At the completion of this class, imagining that you do learn everything that you want to learn, how would you like to experience yourself? For example, how do you want to be feeling in your body? How do you want to be experiencing your mind, your emotions, your connections with other people, etc.?			
17. How do you feel about the future?			
18. Are you currently working with a medical doctor (MD)?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
State diagnosis given by MD (if applicable):			
19. Last physician or health care practitioner seen and when?			
20. When was your last blood test and what was it for?			
21. What are your chief health concerns? (in order of importance to you)			
22. List any accidents, injuries, and hospitalizations (including type and year of occurrence):			
23. What is your: weight now? max. weight? min. weight? height?			
Have you lost or gained any weight lately?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If so, how many pounds?			

24. Describe you family/work relationships:

25. List important events/experiences in your life:

26. List any medical treatments you are undergoing and/or medications you are currently using (if applicable), including dosage and duration of use:

27. Please indicate if you have worked or are currently working with other practitioners (e.g. chiropractor, physiotherapist, professional counsellor, psychologist, social worker, etc.). If in the past, please state when and duration of treatment:

28. How is your sleep (include usual time of sleep and wake, daytime naps, and any difficulties in falling asleep or staying asleep):

29. How is your energy (best and worst time of day):

30. Do you exercise? Yes No
If yes, include type, frequency and duration:

31. How long have you had your current health problems?

32. What is a typical day like for you?

33. How much effort are you willing to put into your health? Please rate from 1 – 10:

34. How important are each of these things in your life? Please rate from 1 – 10: Career ___ Money ___
Health ___ Romance ___ Fun & Recreation ___ Personal Growth ___ Family & Friends ___ Physical
Environment ___

Please add anything else that is important for the instructor to know about you and your situation.

Thank you for taking the time to fill out this form.