Summer 2015- 156/125

DATE_____
Class Chosen: _____

Orientation Questionnaire (OQ)

CENTER FOR MINDFULNESS IN MEDICINE, HEALTH CARE, & SOCIETY™

MINDFULNESS-BASED STRESS REDUCTION PROGRAM

UNIVERSITY OF MASSACHUSETTS MEDICAL SCHOOL
Division of Preventive & Behavioral Medicine

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) **Office use only**

Center for Mindfulness in Medicine, Health Care, and Society

University of Massachusetts Medical School
UMASS

1. What is your main reason for participating in the Stress Reduction 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?

_____

Date: _____

How did you learn about this program?

We are interested in knowing how you learned about our program. Would you help us by checking off any and all of the ways you first learned about the 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 _____

_____ Harvard Pilgrim Health Care

____ Tufts Health Plan

_____ I received an appointment reminder with information regarding the 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):_____

This is a good time to

Stop…

and await further directions from your Orientation Session Instructor.

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

1)
_____
_____
_____

2)
_____
_____
_____

3)
_____
_____
_____

STRESS REDUCTION PROGRAM
UMASS MEDICAL SCHOOL
INFORMED CONSENT AGREEMENT

The risks, benefits and possible side effects of the 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 UMMS 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 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 Stress Reduction Program experience.

___I DO NOT give permission to communicate via email.

Signature: _____ Date: _____