# STRESS REDUCTION CLINIC

## CLIENT INFORMATION, AGREEMENT, AND CONSENT FORM

**Please read and complete all information requested** Date:

___________________

Client First Name________________ Middle Initial______ Last

Name____________________

Address______________________________________________________________________

______

City_____________________State______________Zip _______________

Home Phone___________________________ Work Phone__________________________

Cell Phone______________________ E-mail

Address_____________________________________

Can we leave messages at: Home? __ Work?______ Cell?_______E-mail__________________

Birth Date__________ Male________Female______Single_______ Married_____

Other________

Ethnicity: African-American Asian Caucasian Hispanic Multi-Racial Other

Social Security #_________________ Who Referred

You?_________________________________

Name of Faith

Community___________________________________________________________

Employer_______________________ Full-Time Student_________Part-time

Student____________

Please state briefly your reasons for seeking Stress Management

tools_____________________

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In registering for participation in the Stress Reduction Clinic, it is my intention to:

______Attend eight classes of instruction

______Complete homework assignments (approx. 30-45 minutes per class for eight weeks)

______Attend Silent Retreat

My hope and intention is that as a result of my commitment to practicing meditation tools, I will experience: (your personal hopes or desires for personal changes)_____________________________

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# STRESS REDUCTION CLINIC

## Application for Scholarship Assistance

Name___________________________________________Date of Application_______________

Date of Clinic Program you will enter_____________________________________________

Number of people in your household (under 18)__________(over 18)___________ Total________

Gross Annual Salary of working adults in household _____________

Interest or dividend income received (annually) _____________

Retirement Income – Social Security and/or other _____________

Rental Income _____________

Regular support from relatives _____________

Child Support _____________

Any other regular source of income _____________

Approximate Total Annual Income _____________

*By signing below I am indicating my desire to apply for scholarship assistance toward the cost of participating in the Stress Reduction Clinic. I understand that the availability of these scholarships are subject to change depending upon the availability of funds.*

Full cost of eight week SRC program, Registration Fee and Deposit  $500.00

Scholarship requested for:

Proposed Payment
Plan________________________________________________________

______________________________________________________

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**STRESS REDUCTION CLINIC**
Medical Release Form

SEMINAR PARTICIPANTS: This medical release form must be completed by a physician and is required for participation in the MBSR Clinic. This form must be presented prior to the first class attended.

PARTICIPANT NAME________________________________PHONE (      )___________

ADDRESS_______________________________________________________________

CITY_____________________________ STATE__________ ZIP__________________

IN CASE OF EMERGENCY NOTIFY_____________________PHONE (      )___________

RELATIONSHIP_____________________________

PHYSICIANS: This medical release form must be completed by you in order to allow your patient to participate in the MBSR clinic. Participation will involve mild physical activity such as stretching, yoga-type exercises, and slow walking. The clinic will also teach behavioral practices involving breathing, exercise of personal choice and meditation to help reduce symptoms of stress in everyday life.

PHYSICIAN CONSENT: I authorize my patient _____________________________ to participate in the activities in the MBSR clinic with the following restrictions:

______ Initial here if no restrictions apply

Otherwise, please indicate restrictions in the space provided below:

_____________________________________________________________

_____________________________________________________________

_____________________________________________________________

_____________________________________________________________

_______________________________________________________________________

PHYSICIAN SIGNATURE: _________________________________

Printed Name of Physician: _________________________________

Address of Physician: _________________________________

_________________________________

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Physician's Phone Number: (_____)______________________________