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

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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