Mind-Body Skills Group Intake Form

Date: _____ **Soc. Sec. #:** _____ **Birth Date:** _____

Name: _____
LAST FIRST MIDDLE INITIAL MAIDEN

Address: _____
CITY STATE ZIP

Sex: ☐ **M** ☐ **F** ☐ **Single** ☐ **Married** ☐ **Partnered** ☐ **Divorced** ☐ **Widowed** ☐ **Separated**

Home Phone: _____ **Work:** _____ **Cell:** _____

Employer: _____ **Occupation:** _____

Work Address: _____

Spouse/Partner's Name: _____ **# of Children: Boys** _____ **Girls** _____

Who should we thank for referring you? _____
NAME OCCUPATION/RELATION

In case of emergency, whom should we contact? _____
NAME RELATION PHONE

Are you currently under medical treatment? ☐ **Yes** ☐ **No**
Please Describe: _____

Have you ever had any serious illnesses or operations? ☐ **Yes** ☐ **No**

Please Describe: _____

Are you currently taking any medications? ☐ **Yes** ☐ **No** (Continue list on back of sheet if needed.)

Name of Medication	How much do you take?	How did you come to take this?

Are you currently taking any nutritional supplements? ☐ **Yes** ☐ **No** (Continue list on back of sheet if needed.)

Name of Supplement	How much do you take?	How did you come to take this?

What do you hope to learn or experience by joining this mind-body skills group?_____

Family History:

	Name	Health	Age	Major Illnesses	Died	Cause of Death
Father		Good/Poor				
Mother		Good/Poor				
Brother(s) 1.		Good/Poor				
2.		Good/Poor				
3.		Good/Poor				
Sister(s) 1.		Good/Poor				
2.		Good/Poor				
3.		Good/Poor				

Do you smoke? ☐ **Yes** ☐ **No** **How many packs per day?** _____
Do you drink coffee? ☐ **Yes** ☐ **No** **How many cups per day?** _____
Do you drink alcohol? ☐ **Yes** ☐ **No** **How many drinks per day?** _____
Do you drink soda? ☐ **Yes** ☐ **No** **How many drinks per day?** _____
Do you use other drugs? ☐ **Yes** ☐ **No**
Do you eat regular meals? ☐ **Yes** ☐ **No** **How many meals per day?** _____ **Snacks?** _____
Do you sleep regularly? ☐ **Yes** ☐ **No** **How many hours per night?** _____
Do you exercise? ☐ **Yes** ☐ **No** **What type(s)?** _____ **How often?** _____

Are you overly stressed in your current work situation? ☐ **Yes** ☐ **No**
Are you overly stressed in your current home/family situation? ☐ **Yes** ☐ **No**
If you answered yes, to either of the above questions, please describe: _____
_____
_____

Do you feel supported in your current work environment? ☐ **Yes** ☐ **No**
Do you feel supported in your current home/family situation? ☐ **Yes** ☐ **No**

Do you have a support system/network? ☐ **Yes** ☐ **No** Please check all that apply:

☐ Family ☐ Friends ☐ Spouse/Partner ☐ Community Groups ☐ Physician(s)/Nurse(s)
☐ Church/Religious Organization ☐ Other healthcare professionals _____
☐ American Cancer Association ☐ Other _____

What feeds/sustains your life? _____
_____
_____

What drains your life? _____
_____
_____

What gives you a sense of hope? _____
_____
_____

Have you ever had a profound spiritual experience? ☐ **Yes** ☐ **No**
Do you have concerns for any other individuals at this time? ☐ **Yes** ☐ **No**
What is your greatest concern at this time? _____
_____
_____

What do you see as your greatest hurdle at this time? _____
_____
_____