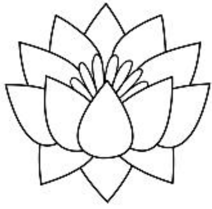

Jefferson County Health Department Integrative Health Initiative

"Moving Forward De-Stress Clinic"
Acupuncture/Acupressure &
Relaxation Centered Program for Stress–Related Conditions

Confidential Registration & Questionnaire

Welcome! Please fill out and sign these forms, and return to our coordinator, Ardyth Gilbertson, RN via email at ardythg@gmail.com, fax or mail to the address below. ***The questionnaire is for the health providers' eyes only**.* Please return ASAP to be considered for the clinic (before the first week of class). Thank you! ☺

Name: ____

Name for nametag: ____

Age & Gender: ____

Address: ____

City, State, Zip: ____

Home & Cell #s: ____

E-mail: ____

Emergency: ____
(Contact, Relationship, & Phone)

How did you hear about us? Is there a particular person we can thank for the referral?

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1. Please tell us a little about yourself (i.e. things like job, children, hobbies, anything you'd like to share so we can get to know you a little better!)

2. Briefly describe the major stressors in your life (i.e. what brings you to the "Moving Forward De-Stress Clinic" at this time). Use another sheet if needed.

3. Please list the <u>specific</u> changes in your life that you hope will come as a result of this clinic. (What do you want to accomplish?)

4. IF you have anxiety, depression, a mental illness, addiction or active drug/alcohol dependency, describe briefly. Are you in Recovery – How long? Describe briefly. And if you have a professional caring for you, please list the <u>name and contact information.</u>

5. Are there any health conditions that would interfere with your ability to fully participate in the mindful movement/gentle yoga (stretching) portion of this course? If yes, please describe your limitations and what adaptations you might need.

6. List any barriers to your ability to attend all 9 sessions of the "Moving Forward De-Stress Clinic" (ie: Transportation, Childcare, etc.)

7. List the Supports you have in place to help you commit to attend the entire Clinic, & sustain your Recovery/ Prevent Relapse (ie: Transportation, Childcare, Family Support, Friend Support, Recovery Support, Professional Help, etc.)

8. What would make your life just what you want it to be?

Printed Name____

Signature of Participant ___________________________________ **Date:** _______________

Please email this form to ardythg@gmail.com, OR fax/mail to:

JCHD – Att'n: Ardyth Gilbertson, RN
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Kearneysville, WV 25430
Phone: 304-728-8416
Fax: 304-728-3319