|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date:**  Click or tap to enter a date. | | | | **Program Facilitator**: Click or tap here to enter text. | | | | | | |
| **Full Name (as it appears on your Health Card):**  Click or tap here to enter text. | | | | | | | | **Date of Birth: (** **yyyy/mm/dd)**  Click or tap here to enter text. | | |
| **OHIP Number:**  Click or tap here to enter text. | | **Version Code:**  Click or tap here to enter text. | | | | | | **Expiry Date (yyyy/mm/dd):**  Click or tap here to enter text. | | |
| **My pronouns are:**  she/her  he/him  they/them  other | | | | | | | | | | |
| **Street Address:** Click or tap here to enter text. | | | | | | | | | | |
| **City:**  Click or tap here to enter text. | | **Province / State:**  Click or tap here to enter text. | | | | | | **Postal Code / Zip Code:**  Click or tap here to enter text. | | |
| **Home Phone:**  Click or tap here to enter text. | | | **Work Phone:**  Click or tap here to enter text. | | | | | **Mobile Phone:**  Click or tap here to enter text. | | |
| **Email**: Click or tap here to enter text. | | | | | | | | | | |
| **Next of Kin Contact *(will only be contacted in an emergency and with your permission, if possible):*** | | | | | | | | | | |
| **Name:**  Click or tap here to enter text. | | **Relationship:**  Click or tap here to enter text. | | | | | **Contact Phone:**  Click or tap here to enter text. | | | |
| **Family Doctor:**  Click or tap here to enter text. | | | | | **Family Doctor Phone:**  Click or tap here to enter text. | | | | | |
| **How did you hear about this program?** Click or tap here to enter text. | | | | | | | | | | |
| **If through online search, what keywords did you use?** Click or tap here to enter text. | | | | | | | | | | |
| **Name of Physician who referred you to this program:**  Click or tap here to enter text. | | | | | | | | | | |
| **Have you attended the Mindfulness-Based Chronic Pain Management (MBCPMTM) program previously?**  Yes  No | | | | | | | | | | |
| **Have you previously attended any other Mindfulness courses?**   Yes  No | | | | | | | | | | |
| Have you practiced meditation before?  Yes  No | | | | | | | | | | |
| **Patient/Client Confidentiality:** | | | | | | | | | | |
| I agree to keep all group conversations and participant happenings witnessed by me during this program confidential and will not discuss, share, divulge, or communicate in any way this private/confidential knowledge. | | | | | | | | | |  |
| I agree to using a reasonable location to provide privacy when participating in this online program, or use headphones. | | | | | | | | | |  |
| I agree to participating or listening to the sessions when not driving or operating machinery and will attempt to give my full attention when in session. | | | | | | | | | |  |
| I further agree to respect all participants’ rights to confidentiality and privacy outside of the program, both for the duration of the program and subsequently after the training. | | | | | | | | | |  |
| I also agree to request help from my health care professionals, including securing therapy if particularly difficult feelings arise for me as a result of taking this program. | | | | | | | | | |  |
| Signature: | Click or tap here to enter text. | | | | | Date: | | | Click or tap to enter a date. | |