



MindfulnessUK
Teacher Training Centre

FULL CLIENT ASSESSMENT FORM

NAME:		Date:	
ADDRESS:			
TELEPHONE:	Day:	Even:	MOBILE:
EMAIL:		DOB:	
OCCUPATION:			
Doctor's details If applicable:			
How did you find out about MindfulnessUK? Referral or self- referral?			

Main reason for attending	
What is your intention and expectations of mindfulness and the teacher?	

Please identify 3 goals	1) 2) 3)
Have you been hospitalized in the last year for any reason? Details.	
Are you on any prescribed medication? Do you take any recreational drugs? Details	

Do you have any physical, psychological, emotional, lifestyle or attitudinal issues? (Suicidality if appropriate)	
Have you suffered with any trauma or significant difficulties that would be helpful for the teacher to know about? Details	

Suffering from any of the following conditions:		
Anxiety Arthritis Panic attacks High or low blood pressure Asthma or other	IBS Back, neck or knee pain Diabetes Glaucoma or eye	Heart or circulation problems Hearing difficulties Digestive complaints Menstrual or hormonal problems

breathing problems	problems	Broken, fractured or dislocated bones in past 2 years?
Artificial joints	Disc problems	
Cancer	Depression	
Suicidal thoughts	Headaches, dizziness, epilepsy, vertigo or difficulties concentrating	

Sleep patterns:	
Allergies/ sensitivities:	

Treatments from other health professionals in the last 3 years	
Support at work, home and socially	
Practical considerations: How many sessions can you commit to? How much time do you have to do home practice? Do you have any questions regarding the practice?	
Do you have any difficulties that we need to know about so I can support your learning? eg Hard of hearing, padded	

chair, interpreter, CD, printed handouts	
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Lifestyle Questions

Smoke:	/ day	Diet	
Drink: - tea	/ day		
coffee	/ day		
alcohol	/ week	Exercise	
other fluids	/ day		

Hobbies/relaxation	
Stress levels	

Past meditation/ mindfulness experience:	
what	
where	
how long	
response and support	

Past yoga or other mindful movement practice:	
type	
when	
response	

The next section is to be completed if the client experiences pain.

When is pain worst	Morning	Afternoon	Evening	Night								
How much does pain interfere with sleep?												
Does not interfere	0	1	2	3	4	5	6	7	8	9	10	Completely interferes
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Three things that make the pain better and three that make it worse	
Better	Worse

Is there anything else we can do for you to support your learning?

Consent

Everything you share with me is strictly confidential and will only be shared with another professional if you or someone else is at risk.

All information is stored and destroyed in adherence with The General Data Protection Regulation (GDPR).

All the information I (client) have provided is true on the date given.

Date:

Signed by client:

Signed by teacher: