# Mindful Eating Application Form

I would be grateful if you could answer the following questions.

I realise the personal nature of these questions. I ask them in order to make sure that taking part is right for you, and to make sure that I support you appropriately during the programme.

All information provided on this form will be kept strictly confidential, and destroyed at the end of the programme. It will not be reported in any subsequent publications or reports generated from this research.

Please either write your answer in the space provided or circle the answer(s) that best apply to you.

|  |  |  |
| --- | --- | --- |
| 1 | Name: |  |
| 2 | Email address |  |
| 3 | Home address: |  |
| 4 | Mobile phone number: |  |
| 5 | Emergency contact details | Name: |  |
| Relationship to you: |  |
| Phone number: |  |
| 6 | If you are a UWE staff member, please state what programme or service you work on: |  |
| If you are a UWE student, please state what programme and year you are on: |  |
| 7 | How would you describe your relationship status? | SinglePartneredMarried/Civil PartnershipSeparatedDivorced/Civil Partnership DissolvedOther:  |
| 8 | Are there any foods you cannot eat for medical reasons? Or are you allergic to any scents or fabrics? | Yes | No |
| If so, please list: |  |
| 9 | Please describe the quality of your sleep: |  |
| 10 | How many hours per night, on average? |  |
| 11 | How many cigarettes do you smoke per day? |  |
| 12 | How many caffeinated drinks do you have per day? |  |
| 13 | Do you use drugs or alcohol?If so, how much: | Yes | No |
| If so, how much: |  |
| 14 | Do you have a history of substance abuse? | Yes | No |
| 15 | Do you take any prescription medications? | Yes  | No |
| If yes, please list: |  |
| 16 | Have you ever experienced any abuse as an adult? (Please circle those that apply) | None Physical MentalEmotional Spiritual RitualSexual Other |
| 17 | Have you ever experienced any abuse as a child? (Please circle those that apply) | None Physical MentalEmotional Spiritual RitualSexual Other |
| 18 | Do you currently live in a safe setting? | Yes | No |
| 19 | Have you experienced a period of high stress in the last year (i.e. due to redundancy, bereavement, illness etc.)? | Yes | No |
| If yes, please specify: |  |
| 20 | Are you currently engaged in psychotherapy? | Yes | No |
| If no, have you been in therapy during the last three years? | Yes | No |
| 21 | Have you ever been hospitalised overnight for psychological treatment? | Yes  | No |
| If yes, what year was this: |  |
| 22 | During the last MONTH have you:a. Considered suicide? b. Sought psychiatric help? c. Had thoughts of death or dying? d. Had urges to beat, injure or harm someone? e. Had urges to smash or break things?  | YesYesYesYesYes | NoNoNoNoNo |
| 23 | Do you currently have any mental ill-health issues or concerns, such as anxiety, depression, PTSD or psychosis? | Yes | No: |
| If yes, please provide details: |  |
| 24 | Do you eat a balanced diet? | Yes | No |
| 25 | Are you currently on any kind of weight loss diet? | Yes | No |
| 26 | What kind of exercise do you do? |  |
| How frequently? |  |

Thank you!