# 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.

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? | | | | | | | | | | | Single  Partnered  Married/Civil Partnership  Separated  Divorced/Civil Partnership Dissolved  Other: | | | | | | | | |
| 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 Mental  Emotional Spiritual Ritual  Sexual Other | | | | | | | | | | |
| 17 | Have you ever experienced any abuse as a child? (Please circle those that apply) | | | | | | | | | None Physical Mental  Emotional Spiritual Ritual  Sexual 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? | | | | | | | | | | Yes  Yes  Yes  Yes  Yes | | | | | No  No  No  No  No | | | | |
| 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? | | | |  | | | | | | | | | | | | | | | |
| 27 | Do you have any previous experience of meditation? | | | | | | | | | | | | | Yes | | | | | | No |
| If yes, how often do you meditate? (E.g. daily, once a week, etc.) | | | | | | | | | | | | |  | | | | | | |
| And how long have you been doing this for? (E.g. 6 months, 3 years, etc.? | | | | | | | | | | | | |  | | | | | | |
| 28 | Do you ever worry about food or eating? | | | | | | | | | | | | | Yes | | | | | | No: |
| 29 | Do you worry that you have lost control over how much you eat? | | | | | | | | | | | | | Yes | | | | | | No |
| 30 | Would you say that food dominates your life? | | | | | | | | | | | | | Yes | | | | | | No |
| 31 | Have you ever:   1. Binged on food? 2. Induced vomiting? 3. Taken laxatives? 4. Severely restricted your eating? 5. Engaged in any other disordered eating behaviours? | | | | | | | | | | | | | Yes  Yes  Yes  Yes  Yes | | | | | | No  No  No  No  No |
| 32 | If so, how many times have you done this in the last week: | | | | | | | | | | | | | | | | | | | |
| 33 | Have you ever been diagnosed with an eating disorder? | | | | | | | | | | | | | Yes | | | | | | No |
| If so, which one: | | | | | | | | | | | | | | | | | | | |
| 34 | Are you currently in treatment for this eating disorder? | | | | | | | | | | | | | Yes | | | | | | No |

**Thank you!**