Yoga for Stress Resilience (YSR)/Mindful Self-Compassion (MSC)
Background Information Form

Please provide the following background information to help Dr.Vaidya assess if the YSR/MSC program would be helpful to you at this time and to support you during the program. This information will only be read by Dr. Vaidya. If you feel uncomfortable answering any questions, please note that on the form and have your family doctor send in the referral form to book an appointment.

Program dates: ……..

Name and Address ……..

……

Date of Birth …… **Occupation**…….

OHIP Number (Mandatory)……

Family Doctor (Name and Fax Number)……..

Emergency Contact Information: ……

Why are you interested in participating in this at this time? Please be advised that YSR is primarily designed for burnout, MSC is for personal growth and development.

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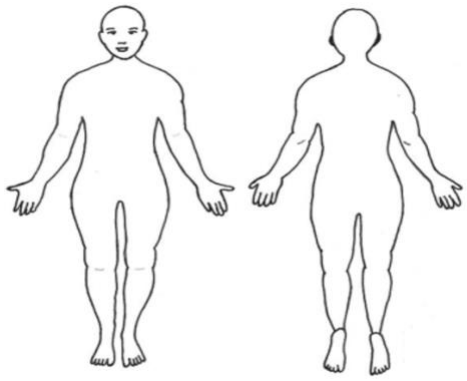
Do you have any medical/health issues or physical limitations? [ ]Yes [ ]No

If yes, please describe. …….

……

……..

Please circle area where you experience pain, or limitations and describe:



Please indicate any restrictions you may have to the following:

Sitting or lying on the floor:……

Balancing Exercises:……

Walking:……

Other: ……

Please list your current medications: ……..

……..

……..

Please list your current consumption of the following substances:

Marijuana:……Alcohol:……Other drugs:……

Are there any stressful life circumstances that might make this program difficult for you at this time (e.g. substance use, anger issues, fasting, pain, legal issues).

……

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Are you currently seeing a therapist or counselor? [ ]Yes [ ]No
Is your Primary Care Provider/Counselor aware you are attending this program? [ ]Yes [ ]No

In the unlikely event of an emergency, may we contact your primary care provider or counselor? If so, please provide contact information:

……

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Is there anything else that might be helpful for Dr Vaidya to know at this time?

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I understand that lying or withholding information from Dr.Vaidya about my health will affect my ability to participate safely in this course. At the present time, I am planning to participate in the entire course (including the 3-hour retreat for MSC), and to commit at least 30 min/day (formally or informally) to practice.

Signature:…… Date:……

Release of Medical Information:

Dr. Shailla Vaidya MD MPH CCFP(EM) C-IAYT
1466 Bathurst St, Suite 306 Toronto, ON M5R3S3
Phone: 416-536-5555 Fax:416-536-3352

To (Please provide name of Family Doctor/Primary Care Provider/Specialist):

Fax Number:

Dear Primary Care Provider,

Your Patient _____ is interested in participating in my Therapeutic Yoga Burnout Recovery Program. This program is based on the principles of mindfulness, self-compassion, mind-body medicine and human performance. It incorporates gentle mindful, breath based movement. It is intended for those suffering from stress-related illness and caregiver strain/burnout.

Please provide the CPP as well as any other medical information, including mental health and physical limitations, to assess appropriateness/fit for the group, and to assist in providing appropriate care for this patient.

Thank You.

Sincerely,

Dr. Shailla Vaidya

I _____
Hereby authorize and direct _____ to provide to Dr. Shailla Vaidya, my medical information, including copies of my medical records.

Signature: _____ Date:_____

Witness:_____ Date: _____