

# EMPOWER THE MIND BY USING THE BODY

## StrongMIND

### PROGRAM OVERVIEW

StrongMIND is a 12-week program that will take participants through 3 levels of exercise. The goal is to promote positive thinking habits by focusing on the present during mindful exercises. This program is beneficial for those who are living with PTSD, anxiety, depression, or other mental health barriers.

### THE LEVELS

**Level one:** This level focuses on breathing and yoga. These practices are beneficial for focusing your thoughts on the present and relaxing the muscles.

**Level two:** This level focuses on aerobic fitness; primarily walking and cycling. This trains the mind and body on how to adapt certain bodily sensations experienced during exercise.

**Level three:** This level focuses on strength and cardio training. These exercises promote the release of endorphins in order to improve overall well being.

### TO QUALIFY:

- Be 18 years old or older
- Receive clearance and referral from a provider to participate in physical activity and one from a mental health professional

### LEARN MORE

For more information about the program, contact Sarah Knowlton (803) 774-2507



PRISMA HEALTH  
Tuomey Hospital

PRISMA  
HEALTH SM

# StrongMIND

Session Dates: January 21 - April 9, 2020

10:30am - 11:30am

Now accepting applications

Wear comfortable clothing for physical activity.

Please bring this referral to the Sumter YMCA to register for the program. Eligibility will be confirmed prior to program start date.

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## PROGRAM REFERRAL

Provide a referral for your participant to enroll in **StrongMIND** today.

PARTICIPANT'S NAME: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_  
DATE OF BIRTH: \_\_\_\_\_

### Please check requirements for eligibility:

- Age 18 years or older Y/N
- Meet the requirements of the DSM-5 or other related assessments for mental health barriers such as PTSD, anxiety, and/or depression Y/N

Referring Party for Physical Activity:

\_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
PHONE #: \_\_\_\_\_

Referring Party for Mental Health:

\_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
PHONE #: \_\_\_\_\_

\_\_\_\_\_  
Referring Party Signature / /  
Date

\_\_\_\_\_  
Referring Party Signature / /  
Date

\_\_\_\_\_  
Participant Signature / /  
Date

\*I authorize the use and disclosure of my health information for the purpose of this program.