HEALTH QUESTIONNAIRE and HISTORY RECORD

Important

The information supplied to the practitioner by the client is entirely voluntary. This document is completed with the understanding that it is the choice of a client to receive breathing training on this and return occasions. You understand the breathing training practitioner cannot prescribe a medical treatment or prescribe pharmaceuticals. Breathing training does not take the place of medical treatment and when in doubt you should consult your doctor. You agree not to attempt to teach breathing retraining to other individuals

You agree you have stated all medical conditions, treatments, medications or information required to complete an informed breathing training session and you will keep the practitioner updated on any changes to information prior to future sessions. You therefore declare that all information supplied will be true and correct to the best of your knowledge. This information will remain private and confidential unless written authorisation is given by the client to release file details, or when verbal consent is given to send a report/letter to a doctor or other health practitioner who has referred or recommended you to our practice.

CLIENT NAME ……..…… DATE…….

CLIENT SIGNATURE ……..… (GUARDIAN SIGNATURE IF CLIENT UNDER 18YEARS)

I give consent for a report to be sent to my doctor/health practitioner

CLIENT SIGNATURE ……... DATE…….....

PERSONAL DETAILS: Mr. Mrs. Ms. Miss. (Please circle)

FIRST NAME_____ SURNAME_____

Parent's name if under 18 _____

ADDRESS: _____

_____ POST CODE: _____

TELEPHONE: (HOME) _____ (WORK) _____ (MOBILE) _____

PRINT EMAIL ADDRESS CLEARLY PLEASE: _____
(For Appointment reminders, news, notification of publications, hints, and session schedules)

AGE: _____ DATE OF BIRTH: _____ OCCUPATION: _____

Name ----------

Medical background - please give details of all illnesses suffered

EVER SUFFERED THIS?		PRESENT SEVERITY
TICK IF YES	*FROM WHAT AGE?*	(Please circle) 0 = not present now; 1 = mild; 2 = moderate; 3 = severe
[ ] ANAEMIA	…….	0 1 2 3
[ ] ALLERGIES	……	0 1 2 3
[ ] ASTHMA	……	0 1 2 3
[ ] ANXIETY	……	0 1 2 3
[ ] BRONCHIECTASIS	……	0 1 2 3
[ ] CHRONIC FATIGUE SYNDROME	……..	0 1 2 3
[ ] CANCER	……..	0 1 2 3
[ ] CYSTIC FIBROSIS	……..	0 1 2 3
[ ] DIABETES	……..	0 1 2 3
[ ] EMPHYSEMA / COPD	……..	0 1 2 3
[ ] EPILEPSY	……..	0 1 2 3
[ ] HEART CONDITION (specify)	……..	0 1 2 3
[ ] HIGH BLOOD PRESSURE	……..	0 1 2 3
[ ] LOW BLOOD PRESSURE	……..	0 1 2 3
[ ] KIDNEY DISORDER	……..	0 1 2 3
[ ] HYPOGLYCAEMIA	……..	0 1 2 3
[ ] MIGRAINE HEADACHES	…….	0 1 2 3
[ ] MULTIPLE SCLEROSIS	…….	0 1 2 3
[ ] SCHIZOPHRENIA	…….	0 1 2 3
[ ] IRRITABLE BOWEL SYNDROME	…….	0 1 2 3
[ ] SLEEP APNOEA	…….	0 1 2 3
[ ] OTHER ILLNESSES	…….	0 1 2 3

Date of most recent hospitilisation: _____

Reason for hospitalisation: _____

Other hospitalisations: _____

What is your most severe health problem: _____Regularity of episodes: _____

Smokers: How many cigarettes do you smoke per day? _____

Females: Are you pregnant: Yes / No

Have you had your tonsils removed? Y / N Have you had root canal therapy? Y / N

Do you have a family history of: Hay fever: Y / N Allergies: Y / N Asthma: Y / N

How many times have you used antibiotics in the last two years? _____

Name of medical practitioner: _____Telephone_____

Name of specialist: _____Telephone_____

Referred to our breathing centre by: _____

Known allergies to drugs: _____

What do you hope to gain from improving your breathing?

.....

……

Current medication Name ----------

Please record all medication that is currently being used

Antibiotics	**Anti-depressants**
Relaxants/Sleeping Pills	**Heart Medication**
Blood Pressure Medication	**Diabetic Medication**
Asthma, COPD medications (see below)	**Other (please specify)**

Asthma / COPD Medications -Puffers/ Turbo halers/ Tablets/ Nebulisers

Name of Medication	**Strength** In mcg or µg	**No. of doses am** (Give range if varies)	**No. of doses pm** (Give range if varies)
E.G. – SERETIDE BOTH components	**250 µg /50 µg**	**2**	**2**
E.G. - VENTOLIN		**2-8 per day**	**2-4 overnight**

Sleep Disordered Breathing Treatments and Appliances

Have you had a SLEEP STUDY? NO YES **WHEN?** _____

Treatments/ Appliances	**Recommended Yes / No**	**Tried it Yes / No**	**Currently using? Since when?**	**Successful?**
CPAP machine				
Dental Splint				
Surgery to palate/uvula				
Nasal/Sinus Surgery				

If you stopped using CPAP or wearing a dental splint, what was the reason? ----------

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Name ----------

Symptom Questionnaire

INSTRUCTIONS: The symptoms listed below have been associated with incorrect breathing.
Please circle or highlight each individual symptom that you experience at least once a week, or which are significant at certain times of the year. It is not uncommon to have 15 or more different symptoms.

Upper chest breathing
Fast or heavy breathing
Blocked nose
Post nasal drip
Asthma
Chest tightness
Wheezing
Short of breath at rest
Short of breath on exertion
Prone to Colds
Mucous congestion
Loss of sense of smell
Lung congestion or Bronchitis
Hay fever
Sinusitis
Sneezing
Yawning or Sighing
Throat Clearing
Coughing
Runny nose (number of tissues used/day ( )
Mouth- breathing in day
Mouth- breathing in sleep
Grinding Teeth
Audible breathing during sleep
Snoring
Number of wakings per night ( )
Number of toilet visits per night ( )
Wake self with gasp/snort/choke
-Times/night/week ( )
Sleep apnoea (breathing stoppages) noticed by others
Nasal/sinus congestion on waking

Dry mouth
Abdominal bloating
Belching, Flatulence
Heartburn
Difficulty swallowing
Irritable bowel
Colic

Cold hands or feet
Poor concentration/memory
Irregular, pounding, or racing heart
Chest pains that are not heart related

Anxiety, Tension, Apprehension
Panic attacks
Depression
Fear without reason
Confusion
Fear of sultry air
Feelings of unreality
Sense of "losing the mind"
Spaced out feeling
Light-headed or dizzy
Unsteadiness or fainting
Disturbance of consciousness
Headache
Numbness or tingling hands, feet, limbs, face

Muscle spasms
Muscle pains
Muscle weakness
Tremors and twitching
Pains in bones or joints
Exercise intolerant

Insomnia
Frightening/intense dreams
Restless Legs
Food allergies
Pollen, dust allergies
Chemical sensitivities
Increased thirst
Frequent or urgent urination
Weight gain
Weight loss
Excessive sweating
Clamminess
Generalised weakness or "weak at the knees,"
Bedwetting
Waking up tired
Waking with a headache
Sleepiness during the day
Wanting a day nap
Falling asleep sitting, reading, watching TV, driving
Easily tired
Chronic exhaustion

OTHER SYMPTOMS YOU MAY EXPERIENCE

Symptom Tracker NAME_____

INSTRUCTIONS: **COMPLETE SHADED AREA ONLY** **Please transfer ALL the symptoms you circled on Page 3 to the "Symptoms" column below.**
Now rate them with the "tick system".

In "Assessment 1" column, (today's date) - rate each of your symptoms as to how they are currently, before you commence breathing training. We can then track and assess your progress.

RATE your symptoms - Score their intensity or incidence:
1 tick = intermittent symptoms, not every day. **2 ticks** = symptoms present part of most days or nights.
3 ticks = symptoms virtually all of each day or night. **4 ticks** = symptom present all day or night and **severe.**
Complete assessments 2, 3 and 4 after breathing training. ***Leave box empty if you no longer have the symptom.***

Symptoms	Assessment 1 Date:	Assessment 2 Date:	Assessment 3 Date:	Assessment 4 Date:
Example– Sneezing	√√			
PRACTITIONER USE				
Sound: Silent S, Audible A+, ++, +++				
Diaphragm or upper chest dominant				
Rhythm - regular/ irregular/erratic				
Respiration Rate				
Resting heart rate				
TOTAL SYMPTOM SCORE				
% CHANGE				