

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.....

| |
|--|
| <p>PERSONAL DETAILS: Mr. Mrs. Ms. Miss. (Please circle)</p> <p>FIRST NAME _____ SURNAME _____</p> <p>Parent's name if under 18 _____</p> <p>ADDRESS: _____</p> <p>_____ POST CODE: _____</p> <p>TELEPHONE: (HOME) _____ (WORK) _____ (MOBILE) _____</p> <p>PRINT EMAIL ADDRESS CLEARLY PLEASE: _____ (For Appointment reminders, news, notification of publications, hints, and session schedules)</p> <p>AGE: _____ DATE OF BIRTH: _____ OCCUPATION: _____</p> |
|--|

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

| | | |
|--|-------|---------|
| <input type="checkbox"/> ANAEMIA | ..... | 0 1 2 3 |
| <input type="checkbox"/> ALLERGIES | ..... | 0 1 2 3 |
| <input type="checkbox"/> ASTHMA | ..... | 0 1 2 3 |
| <input type="checkbox"/> ANXIETY | ..... | 0 1 2 3 |
| <input type="checkbox"/> BRONCHIECTASIS | ..... | 0 1 2 3 |
| <input type="checkbox"/> CHRONIC FATIGUE SYNDROME | ..... | 0 1 2 3 |
| <input type="checkbox"/> CANCER | ..... | 0 1 2 3 |
| <input type="checkbox"/> CYSTIC FIBROSIS | ..... | 0 1 2 3 |
| <input type="checkbox"/> DIABETES | ..... | 0 1 2 3 |
| <input type="checkbox"/> EMPHYSEMA / COPD | ..... | 0 1 2 3 |
| <input type="checkbox"/> EPILEPSY | ..... | 0 1 2 3 |
| <input type="checkbox"/> HEART CONDITION (specify) | ..... | 0 1 2 3 |
| <input type="checkbox"/> HIGH BLOOD PRESSURE | ..... | 0 1 2 3 |
| <input type="checkbox"/> LOW BLOOD PRESSURE | ..... | 0 1 2 3 |
| <input type="checkbox"/> KIDNEY DISORDER | ..... | 0 1 2 3 |
| <input type="checkbox"/> HYPOGLYCAEMIA | ..... | 0 1 2 3 |
| <input type="checkbox"/> MIGRAINE HEADACHES | ..... | 0 1 2 3 |
| <input type="checkbox"/> MULTIPLE SCLEROSIS | ..... | 0 1 2 3 |
| <input type="checkbox"/> SCHIZOPHRENIA | ..... | 0 1 2 3 |
| <input type="checkbox"/> IRRITABLE BOWEL SYNDROME | ..... | 0 1 2 3 |
| <input type="checkbox"/> SLEEP APNOEA | ..... | 0 1 2 3 |
| <input type="checkbox"/> OTHER ILLNESSES | ..... | 0 1 2 3 |

Date of most recent hospitalisation: _____

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? -----

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 | Anxiety, Tension, Apprehension |
| Fast or heavy breathing | Panic attacks |
| Blocked nose | Depression |
| Post nasal drip | Fear without reason |
| Asthma | Confusion |
| Chest tightness | Fear of sultry air |
| Wheezing | Feelings of unreality |
| Short of breath at rest | Sense of "losing the mind" |
| Short of breath on exertion | Spaced out feeling |
| Prone to Colds | Light-headed or dizzy |
| Mucous congestion | Unsteadiness or fainting |
| Loss of sense of smell | Disturbance of consciousness |
| Lung congestion or Bronchitis | Headache |
| Hay fever | Numbness or tingling hands, feet, limbs, face |
| Sinusitis | |
| Sneezing | Muscle spasms |
| Yawning or Sighing | Muscle pains |
| Throat Clearing | Muscle weakness |
| Coughing | Tremors and twitching |
| Runny nose (number of tissues used/day ()) | Pains in bones or joints |
| Mouth- breathing in day | Exercise intolerant |
| Mouth- breathing in sleep | |
| Grinding Teeth | Insomnia |
| Audible breathing during sleep | Frightening/intense dreams |
| Snoring | Restless Legs |
| Number of wakings per night () | Food allergies |
| Number of toilet visits per night () | Pollen, dust allergies |
| Wake self with gasp/snort/choke | Chemical sensitivities |
| -Times/night/week () | Increased thirst |
| Sleep apnoea (breathing stoppages) noticed by others | Frequent or urgent urination |
| Nasal/sinus congestion on waking | Weight gain |
| | Weight loss |
| Dry mouth | Excessive sweating |
| Abdominal bloating | Clamminess |
| Belching, Flatulence | Generalised weakness or "weak at the knees," |
| Heartburn | Bedwetting |
| Difficulty swallowing | Waking up tired |
| Irritable bowel | Waking with a headache |
| Colic | Sleepiness during the day |
| | Wanting a day nap |
| Cold hands or feet | Falling asleep sitting, reading, watching TV, driving |
| Poor concentration/memory | Easily tired |
| Irregular, pounding, or racing heart | Chronic exhaustion |
| Chest pains that are not heart related | |

OTHER SYMPTOMS YOU MAY EXPERIENCE
