Eva Knörles **Buteyko** *Institute of Breathing & Health* **Provider N°Au55** The Med Ctr . 18 Rockvale Rd . POBox 443 . Armidale 2350 . ph 6771 3171

12 months MEMBERSHIP

Please enroll me in the **SMART** Breathing Course which entitles me to: 12 MONTHS MEMBERSHIP commencing

/ /2019 , 5 sessions of group instruction, retraining of automatic breathing pattern, life style education, symptom control techniques, stress management strategies, free reviews, free phone support,
Please *mail* the form to **PO Box 443, Armidale, 2350 &** send a non refundable deposit of $100.
Attach a cheque or a copy of your electronic transfer made payable to
Eva Knörles

www.regionalaustraliabank.com.au
BSB: 932 000 account N°: 609 567

Total Fee $595 **(Balance due first day of instruction)**

I understand that the Buteyko course is a series of lectures and practical training in breathing reconditioning and does not constitute medical treatment. I am aware that my medication should be kept handy at all times. Furthermore, I the undersigned, agree to only modify prescribed medication/treatment after direct consultation with a medical doctor.
The method has been clinically proven. Medical trials were conducted in Australia, New Zealand, Canada and the UK. It is listed in the Asthma Management Handbook '06.
The information provided is a guide towards breathing retraining. I do not hold the instructor responsible or liable for my interpretation or manner of application of the information.

Signature: _____

Date: _____
(If under 18 years of age, this form must be signed by a parent or guardian)
My working with children number: WWC1182343E

PARTICIPANT DETAILS

First Name .....

Surname .....

Address .....

.....

Suburb ..... Postcode .....

Phone (ah preferred).....

Email.....

Male/Female ..... Age .....

Occupation :.....

Medical history to date (major illnesses & operations)
.....
.....
.....
.....
.....
.....
.....
.....
.....

Sleep Apnoea:

Have you had a sleep Study? Yes No
Approx when was the sleep study? .....

Are you currently using a CPAP Machine? Yes No
Do you know the pressure? .....
How long have you been using CPAP? .....
How often do you use it ? .....
.....
Have you previously used a CPAP ? Yes No
If Yes, why did you stop using CPAP ?
.....
.....
.....
.....

CURRENT MEDICATION

What difficulties if any did you have with the CPAP ?
.....
.....
.....
.....

Dental:
Do you currently use a mandibular splint or other oral device Yes No
.....
.....
.....
Do you currently or have you in the past had dental braces? Yes No

For what condition are you currently taking ***medication?***

	Every day	As needed
Asthma		
Hay Fever		
Sinusitis		
Blood pressure		
Heart condition		
Reflux		
Anxiety		
Depression		
Diabetes		
Pain		
Inflammation		
The Pill / HRT		
Other		

Do you smoke ? Yes / No N°..... per day

 For an **appointment** contact Eva Knörles on **6771 3171**

smart breathing®

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MEDICAL BACKGROUND

Do you now or have you ever suffered from: *Please tick as appropriate.*

- ❑ Arthritis
- ❑ Asthma
- ❑ Attention Deficit Disorder
- ❑ Anxiety
- ❑ Bi Polar Disorder
- ❑ Bronchiectasis
- ❑ Chronic Fatigue Syndrome
- ❑ Cystic Fibrosis
- ❑ Diabetes Type 1 / Type 2
- ❑ Emphysema/COAD/COPD
- ❑ Epilepsy
- ❑ Eczema
- ❑ Heart Condition
- ❑ High Blood Pressure
- ❑ Hypoglycaemia
- ❑ Low Blood Pressure
- ❑ Kidney Disease
- ❑ Migraine Headaches
- ❑ Multiple Sclerosis
- ❑ Nasal Polyps
- ❑ Schizophrenia
- ❑ Sleep Apnoea
- ❑ Snoring
- ❑ Stress
- ❑ Other (Please specify)……

……

Age originally diagnosed ……

Regularity of your symptoms ……

……

……

Known allergies …… ……..

……

What is your most severe health problem?

……

……

……

Date of most recent hospitalization

……

Symptoms experienced prior to starting the Course. *Please rate your condition*

0=never 1=sometimes 2=frequent 3=very often 4=constant

- ❑ Headaches
- ❑ Short of breath
- ❑ Lack of stamina
- ❑ Mouth breathing
- ❑ Dizziness, brain fog
- ❑ Insomnia
- ❑ Ringing or buzzing in ears
- ❑ Loss of memory
- ❑ Mental fatigue
- ❑ Irritability
- ❑ Fear of sultry air
- ❑ Lack of concentration
- ❑ Loss of smell
- ❑ Fear without reason
- ❑ Apathy
- ❑ Coughing
- ❑ Loss of feeling in the limbs
- ❑ Impotence
- ❑ Dry mouth, bad breath
- ❑ Wake unrefreshed, tired in the morning
- ❑ Allergies
- ❑ Chest pain
- ❑ Asthma attacks
- ❑ Painful & irregular menstrual periods
- ❑ Itching
- ❑ Sore, aching muscles
- ❑ Dryness of skin
- ❑ Diarrhoea
- ❑ Breathless
- ❑ Frequent deep breaths
- ❑ Breathing without pause after exhaling
- ❑ Tightness around chest
- ❑ Short temper
- ❑ Erratic blood sugar levels
- ❑ Trembling & tic
- ❑ Blocked ears
- ❑ Prone to colds and/or flu
- ❑ Flashes before the eyes
- ❑ Shuddering in sleep
- ❑ Restless legs
- ❑ Loss of libido
- ❑ Dry, chapped lips
- ❑ Weight loss or gain
- ❑ Chest breathing
- ❑ Cold hands / feet
- ❑ Varicose veins
- ❑ Frequent physical exhaustion
- ❑ Pains in the bones
- ❑ Anemia
- ❑ Excessive mucus production
- ❑ Frequent sighing
- ❑ Sneezing episodes
- ❑ Constant yawning
- ❑ Cramps
- ❑ Waking frequently at night
- ❑ Trouble getting to sleep
- ❑ Sinusitis
- ❑ Palpitations
- ❑ Loss of consciousness
- ❑ Tingling in the hands & fingers
- ❑ Dysphagia (difficulty in swallowing)
- ❑ Constipation with intermittent diarrhoea
- ❑ Haemorrhoids
- ❑ Frequent urination
- ❑ Abdominal bloating, nausea
- ❑ Fatigue
- ❑ Depression
- ❑ Root Canal Therapy
- ❑ Bleeding gums
- ❑ Nose Bleeds
- ❑ Runny Nose
- ❑ Blocked Nose
- ❑ Hay fever
- ❑ Reflux
- ❑ Teeth Grinding
- ❑ Daytime sleepiness
- ❑ Other (Please specify)

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Are you pregnant? Yes / No

Are you vegetarian? Yes / No

Iron deficient? Yes / No

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