BUTEYKO CLINIC INTERNATIONAL
Accredited by Prof. KP Buteyko

Please complete the questions below as accurately as possible so that your Course Instructor can assist you with your individual condition.

Name: Contact Number:

Parent's name (if applicable) Email address:

Occupation: Does it require much TALKING or PHYSICAL EXERCISE? (Circle)

What condition / symptoms do you have? 1) 2)

When were you first diagnosed with your condition? (years)

Please state which best describes your condition:

Sometimes have symptoms: Continuous symptoms (mild):

Continuous Symptoms (moderate): Continuous symptoms (severe):

How often have you been admitted to hospital for asthma attacks/or other, in the past three years?

Do you feel that deep breathing is good for you? YES NO

	Never	**Sometimes**	**Often**	**Very Often**
Do you feel stressed, anxious regarding your condition?				
Does your nose feel congested?				
Do you breathe through your mouth during the day?				
Do you breathe through your mouth during the night? (Do you wake up with a dry mouth?)				

Have you completed a Sleep Study? YES NO If yes, give approximate date:

Have you been prescribed a CPAP machine? YES NO Do you currently use it? YES NO

Do you Smoke? YES NO IF yes, how many cigarettes a day:

Do you limit your intake of dairy foods? YES NO Has this helped you? YES NO

Approximately how many hours per week do you partake in physical exercise?	Less than one hour	1-2 hours	2-3 hours	3-4 hours	4-5 hours	5-6 hours	6-7 hours	7 or more

Please indicate the level of severity of any of the symptoms that you experience in list below:

Complaint	Mild	Moderate	Severe
Coughing			
Wheezing			
Exercise Induced Asthma			
Frequent Colds			
Breathlessness at rest			
Frequent Sighs			
Frequent Yawning			
Sleep Apnoea			
Snoring			
Lower back pain			

Complaint	Mild	Moderate	Severe
Excessive sweating			
High Perceived Stress			
Tummy upset / IBS			
Achy Muscles			
Tiredness			
Insomnia /Broken Sleep			
Poor Concentration			
Panic Attacks			
Headaches			

Nijmegen Questionnaire: Please indicate the level of severity of any of the symptoms that you experience in list below:

Complaint	Never	Rarely	Sometimes	Often	Very often
Chest Wall Pains					
Feeling Tense					
Blurred vision					
Dizzy Spells					
Confusion, losing contact with reality					
Fast or deep breathing					
Shortness of breath					
Tightness in the chest					
Bloated Feelings in Stomach					
Tingling of fingers					
Unable to Breathe Deeply					
Stiffness in fingers or arms					
Stiffness around the mouth					
Cold hands or feet					
Thumping of the heart					
Feeling of anxiety					
Total:					

If you take asthma medication, please list:

Preventer: Daily Dose:

Reliever: Daily Dose:

What would you like to achieve from attending Buteyko Clinic?

How did you hear about this course:

Social Media	Friend	Newspaper	GP or Consultant	Internet Search	Radio	Health Care Practitioner	Other:

For Female participants: Are currently pregnant: YES NO

DISCLAIMER

Please read the following disclaimer carefully before signing, and/or seek professional legal advice if necessary.

I understand that the Course Instructor is not a registered medical practitioner No advice and activity presented, demonstrated or advised during the Course are in any way intended as a substitute for a medical consultation, and should not replace or interfere with any guidance offered by a medical professional.

I understand that I am free to leave the Course at any time for any reason. If at any time during the Course, I feel the need for any assistance, medical or otherwise, I agree to notify my Course Instructor immediately and take full responsibility for the same, including leaving the course and obtaining appropriate care. If I fail to seek the required medical care or ignore medical advice, including that from my Course Instructor, I understand and agree to do so at my sole risk.

I understand I will need to inform my Course Instructor about my pregnancy status, if any, before starting the Course's training and exercises. If I become pregnant or believe I may be pregnant after starting the Course, I agree to stop all technique exercises immediately and inform my Course Instructor to guide me on the next course of action.

I hereby confirm that I have carefully read this disclaimer and have fully understood that this is a release of liability. I hereby expressly agree to release and discharge my Course Instructor, and/or anybody associated with Sandy Mitchell from any and all claims or causes of action and agree to waive any right that I may otherwise have to bring a legal action against the said individuals for personal injury and/or damage to property.

Full Name of Participant Signature Date

Full Name of Guardian Signature Date

[N.B: Parent / Guardian's signature is mandatory if the participant is below 18 years of age]