REGISTRATION FORM

PLEASE FILL IN ALL THE INFORMATION ON EACH OF THE THREE PAGES:

Name: ____
Address: ____
____
Telephone: work ________________ home ____________________cell__________________
Email: _________________________________
Occupation:_____________________________
Course date:_________________________
Emergency contact: _____________________________Relationship________________
Telephone_______________________

MEDICAL HISTORY

Type of Illness: (e.g. Asthma)____
Degree: (e.g. Mild) ____
Regularity of attacks or problems: ____
Age originally diagnosed: ___________ Current age: ______________________
Medical practitioner: __________________________ Telephone: _____________
Address____
Last time hospitalized for breathing problem: ____________
For another condition:_____________
Date you last took cortisone orally or by injection (eg Prednisone, Prednisolone, Methylprednisone):_________________________________

Have you ever suffered from the following problems?:

Heart Condition	_______	High Blood Pressure	_______
Low Blood Pressure	_______	Epilepsy	_______
Diabetes	_______	Schizophrenia	_______
Kidney Disease	_______	Depression	_______
Under active Thyroid	_______	High Cholesterol	_______
Over active Thyroid	_______	Migraines	_______
Angina	_______	Fluid Retention	_______
Hypoglycaemia	_______	Other	____________________

What drugs are you allergic to?

____

____

What other things besides drugs are you allergic to?

____

____

SYMPTOMS SUFFERED PRIOR TO COMMENCING COURSE

Please place check in space provided

( ) shortness of breath
( ) tightness around chest
( ) headaches
( ) dizziness
( ) loss of memory
( ) lack of concentration
( ) irritability
( ) ringing/buzzing in ear
( ) fear of sultry air
( ) coughing
( ) impotence
( ) far sightedness
( ) allergies
( ) asthma attacks
( ) itching
( ) dryness of skin
( ) loss of hearing
( ) flashes before eye
( ) snoring
( ) weight loss
( ) weight gain
( ) varicose veins
( ) pains in the bones
( ) diarrhea
( ) bleeding veins
( ) breathing through mouth
( ) frequent deep breaths
( ) breathing without pause
( ) insomnia
( ) mental fatigue
( ) short temper
( ) apathy
( ) fear without reason
( ) trembling and tic
( ) loss of feeling in limbs
( ) dryness in mouth
( ) deterioration of vision
( ) pains in heart region
( ) painful/irregular periods
( ) muscle pains
( ) rhinitis
( ) prone to colds/flu etc
( ) shuddering in sleep
( ) loss of libido
( ) chest pains (not heart)
( ) sudden chilling of limbs
( ) physical exhaustion
( ) anemia
( ) loss of smell
( ) frequent sighing
( ) any symptoms not listed

Please list other symptoms: ____

____

What kind of physical exercise do you take?: _______________________________________

____

How often?:____

Please list all drugs you are currently taking, or have taken, in the past two months whether related to breathing difficulties or not. Please write clearly.

Medication (please print)	**Dosage: am. pm.**	**What do you take this for?**

Vitamins and supplements you take, how often, and for what condition: **Please write clearly**

______________________ ____

______________________ ____

______________________ ____

______________________ ____

______________________ ____

I understand that the Buteyko Method Breath Reconditioning Program is a series of lectures and training. It does not constitute medical treatment. Further more, I, the undersigned, agree only to modify prescribed medication after consultation with a medical doctor.
I also agree that, as I am not a trained Buteyko Practitioner, I will not attempt to teach other people without the written permission of Hadas Golan or another certified practitioner**.**

Name: ____

Date: _____________________

Signed: ____

If student is under 18 this form must be signed by a parent of guardian, and those under 16 must be accompanied to class by a parent or responsible adult.