**Important**

The information below is intended to assist the Educator to become familiar with your condition, your expectations of the program and your current medical symptoms. Although any information you complete is not intended to be shared with anyone but your Educator, you acknowledge that you provide it freely and voluntarily for its intended use. This program is not a medical therapy, nor should be used as a substitute for any medical treatment prescribed to you. If unsure, please consult your primary care physician.

Printed Client Name:

Date:

Client Signature:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Guardian signature if under 18 years)

I give consent for a report to be sent to my doctor / other health practitioner ­ YES:  NO:

Client Signature:

Date:

**Personal Details**

Mr.  Mrs.  Ms.  Miss  (Please circle)

First name: Click here to enter text. Last name: Click here to enter text.

Parent’s name if client is under 18: Click here to enter text.

Address: Click here to enter text.

Click here to enter text.

Telephone: (Cell): Click here to enter text. Additional phone: Click here to enter text.

Email: Click here to enter text.

Age: Click here to enter text. Date of birth: Click here to enter a date.

Occupation: Click here to enter text. If retired, previous occupation: Click here to enter text.

Date of most recent hospitalization: Click here to enter a date.

Reason for hospitalization: Click here to enter text.

Other hospitalizations: Click here to enter text.

What is your most severe health problem? Click here to enter text. Regularity of episodes Click here to enter text.

**Smokers:** How many cigarettes do you smoke per day? Click here to enter text.

**Females:** Are you pregnant? **yes  no**

Have you had your tonsils removed? **yes  no**

Have you had any root canals? **yes  no**

Do you have a family history of: Hay fever? **yes  no**

Allergies? **yes  no** Asthma? **yes  no**

Other than for sleep apnea, have you had nasal surgery? What was the reason? Click here to enter text.

Name of doctor/medical practitioner: Click here to enter text. Telephone: Click here to enter text.

Name of specialist: Click here to enter text. Telephone: Click here to enter text.

Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Known allergies to medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Medication:**

Please record all medication you are currently taking:

|  |  |
| --- | --- |
| Antibiotics:  Click here to enter text. | Anti-depressants  Click here to enter text. |
| Relaxants/Sleeping pills  Click here to enter text. | Heart Medication  Click here to enter text. |
| Blood Pressure Medication  Click here to enter text. | Diabetes Medication  Click here to enter text. |
| Asthma / COPD Medications  Click here to enter text. | Other Medications/purpose  Click here to enter text. |
| Herbal  Click here to enter text. | Supplements  Click here to enter text. |

**Asthma / COPD Medication Dosages – Inhalers/Turbohalers/Tablets/Nebulizers**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of Medication** | **Strength** mcg or ug | **Number doses AM** | **Number Doses PM** | **Educator Use only** |
| Example *Advair (****please give dose of BOTH components)*** | 250mcg/50mcg | 2  3-5 per day | 2  2-4 overnight |  |
| Ventolin |  | 3-5 per day | 2-4 overnight |
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**Sleep Disordered Breathing Treatments and Appliances**

Have you had a **Sleep Study**? **yes  no** If yes, when? Click here to enter a date.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Treatments / Appliances** | **Recommended?**  **Yes / No** | **Tried it?**  **Yes / No** | **Currently Using?**  **Since when?** | **Successful?** |
| CPAP machine |  |  |  |  |
| BIPAP machine |  |  |  |  |
| APAP machine |  |  |  |  |
| Dental Splint |  |  |  |  |
| Surgery to palate/uvula |  |  |  |  |
| Nasal/Sinus surgery |  |  |  |  |

If you stopped using a prescribed machine or wearing a dental splint, what was the reason?

Click here to enter text.

What do you hope to gain from improving your breathing?

Click here to enter text.

***Please continue on next page.***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Symptom Questionnaire** | | | | | |
| INSTRUCTIONS: The symptoms listed below have been associated with incorrect breathing. **Please indicate 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.  **Legend** | | | | | |
| **1 = occasional**  **3 = frequent, most of day/night** | | **2 = part of each day/night**  **4 = frequent and/or strong** | | | |
| **Symptom** | **Assessment 1** | | **Assessment 2** | **Assessment 3** | **Assessment 4** |
| **Abdominal bloating** |  | |  |  |  |
| **Achy or tense muscles** |  | |  |  |  |
| **Anxiety, tension, apprehension** |  | |  |  |  |
| **Asthma** |  | |  |  |  |
| **Audible breathing in sleep** |  | |  |  |  |
| **Bedwetting** |  | |  |  |  |
| **Belching, flatulence** |  | |  |  |  |
| **Blocked nose** |  | |  |  |  |
| **Chemical sensitivities** |  | |  |  |  |
| **Chest pains unrelated to heart** |  | |  |  |  |
| **Chest tightness** |  | |  |  |  |
| **Chest wall sore to touch** |  | |  |  |  |
| **Chronic exhaustion / physical exhaustion** |  | |  |  |  |
| **Clamminess** |  | |  |  |  |
| **Cold hands or feet** |  | |  |  |  |
| **Colic** |  | |  |  |  |
| **Confusion** |  | |  |  |  |
| **Coughing** |  | |  |  |  |
| **Depression** |  | |  |  |  |
| **Difficulty swallowing** |  | |  |  |  |
| **Disturbance of consciousness** |  | |  |  |  |
| **Dry mouth** |  | |  |  |  |
| **Easily tired** |  | |  |  |  |
| **Excessive sweating** |  | |  |  |  |
| **Exercise intolerant / lack of stamina** |  | |  |  |  |
| **Falling asleep sitting/reading/watching TV/in a car** |  | |  |  |  |
| **Fast or heavy breathing** |  | |  |  |  |
| **Fear of sultry air** |  | |  |  |  |
| **Fear without reason** |  | |  |  |  |
| **Feelings of unreality** |  | |  |  |  |
| **Food allergies** |  | |  |  |  |
| **Frequent or urgent urination** |  | |  |  |  |
| **Frightening / intense dreams** |  | |  |  |  |
| **General tiredness or weakness** |  | |  |  |  |
| **Generalized weakness or “weak at the knees”** |  | |  |  |  |
| **Grinding teeth** |  | |  |  |  |
| **Hay Fever, sneezing** |  | |  |  |  |
| **Headache** |  | |  |  |  |
| **Heartburn** |  | |  |  |  |
| **Inability to take a deep breath** |  | |  |  |  |
| **Increased thirst** |  | |  |  |  |
| **Insomnia** |  | |  |  |  |
| **Irregular, pounding or racing heartbeat** |  | |  |  |  |
| **Irritability** |  | |  |  |  |
| **Irritable bowel, constipation or diarrhea** |  | |  |  |  |
| **Light-headed or dizzy** |  | |  |  |  |
| **Loss of sense of smell** |  | |  |  |  |
| **Lung congestion or bronchitis** |  | |  |  |  |
| **Many cavities** |  | |  |  |  |
| **Mental fatigue** |  | |  |  |  |
| **Mouth Breathing in sleep** |  | |  |  |  |
| **Mouth breathing when awake** |  | |  |  |  |
| **Mucous congestion** |  | |  |  |  |
| **Muscle spasms/ tremors/ twitching** |  | |  |  |  |
| **Muscle tension, spasms or cramping** |  | |  |  |  |
| **Muscle weakness** |  | |  |  |  |
| **Nasal/sinus congestion on waking** |  | |  |  |  |
| **Needing and taking a day nap (Number of days / week) ( )** |  | |  |  |  |
| **Number of toilet visits per night ( )** |  | |  |  |  |
| **Number of wakings per night ( )** |  | |  |  |  |
| **Numbness or tingling hands, feet, face** |  | |  |  |  |
| **Pains in bones or joints** |  | |  |  |  |
| **Panic attacks** |  | |  |  |  |
| **Pollen, dust allergies** |  | |  |  |  |
| **Poor concentration / memory** |  | |  |  |  |
| **Post-nasal drip** |  | |  |  |  |
| **Prone to colds, flu, chest infection** |  | |  |  |  |
| **Restless legs** |  | |  |  |  |
| **Runny nose (number of tissues/day) ( )** |  | |  |  |  |
| **Sense of “losing your mind”** |  | |  |  |  |
| **Short of breath at rest** |  | |  |  |  |
| **Short of breath on exertion** |  | |  |  |  |
| **Sighing habitually** |  | |  |  |  |
| **Sinusitis** |  | |  |  |  |
| **Sleep apnea (breath stoppages) noticed by others** |  | |  |  |  |
| **Sleepiness during day** |  | |  |  |  |
| **Snoring** |  | |  |  |  |
| **Spaced out feeling** |  | |  |  |  |
| **Throat clearing** |  | |  |  |  |
| **Tremors, twitches, tics** |  | |  |  |  |
| **Unsteadiness or fainting** |  | |  |  |  |
| **Upper chest breathing** |  | |  |  |  |
| **Wake self with gasp/snort etc – times/night ( )** |  | |  |  |  |
| **Waking up tired** |  | |  |  |  |
| **Waking up with a headache** |  | |  |  |  |
| **Weight gain** |  | |  |  |  |
| **Weight loss** |  | |  |  |  |
| **Wheezing** |  | |  |  |  |
| **Yawning when not tired** |  | |  |  |  |
|  |  | |  |  |  |
| ***Other Symptoms not listed*** |  | |  |  |  |
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| **Check if you have any of the following conditions** | | | |
|  | Severe renal failure (includes dialysis) |  | Thrombosis |
|  | Uncontrolled hyperthyroidism |  | Current cancer treatment |
|  | Sickle cell disease |  | Recent heart attack |
|  | Acute schizophrenia |  | Brain tumor |
|  | Chronic Obstructive Pulmonary Disease (some kinds) |  | Uncontrolled hypertension |
|  | Arterial aneurysm |  | History of serious cardiac rhythm disorder |
|  | Hemorrhagic stroke |  | Pregnancy |
| **Check if you have any of the following conditions** | | | |
| x | Angina |  | Depression |
|  | Epilepsy |  | Fluid retention |
|  | High blood pressure |  | High cholesterol |
|  | Low blood pressure |  | Kidney disease |
|  | Hypoglycemia |  | Overactive thyroid |
|  | Migraines |  | Underactive thyroid |
|  | Schizophrenia |  | Diabetes |
|  | Heart Condition (not previously mentioned) |  | Hyperventilation |
|  | Blood disease (not previously mentioned) |  | Panic attacks |
|  | Spinal misalignment |  | Major surgeries |
|  | Life threatening illness |  |  |

Please describe your breathing in detail. Include such things as … Do you breathe with your mouth or your nose? Chest or diaphragm? Fast or slow? Big or small? Silent or audible? Easy or difficult? etc

Click here to enter text.

Draw your breath wave:

**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**THIS PAGE EDUCATOR USE ONLY**

**Educator Use Only Breathing Pattern Assessment**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Assessment 1** | **Assessment 2** | **Assessment 3** | **Assessment 4** |
| **Respiration Rate** |  |  |  |  |
| **Route** |  |  |  |  |
| **Location** |  |  |  |  |
| **Tidal Volume Estimate** |  |  |  |  |
| **Rhythm** |  |  |  |  |
| **Sound** |  |  |  |  |
| **BHT** |  |  |  |  |
| **Heart Rate** |  |  |  |  |
| **Heart Rate/ Walking** |  |  |  |  |

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