Learn to SleepWell

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

CONSULTATION FORM

Mindful Buteyko Breathing

Client details

First name					
Last name					
Address					
City / suburb		State		Postcode	
Phone (mobile)					
Email					
Sex	Male ☐ Female ☐		Age		
Occupation					

Please select answer	**Never**	**Sometimes**	**Often**	**Very often**
Do you feel stressed, anxious regarding your condition?	☐	☐	☐	☐
Is your nose blocked?	☐	☐	☐	☐
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:_____ and provide a copy of your Sleep Study.

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? _____

How many hours a week do you partake in **physical exercise**?

<1 hour	**1-2 hours**	**2-3 hours**	**3-4 hours**	**4-5 hours**	**5-6 hours**	**6-7 hours**	**> 7 hours**
☐	☐	☐	☐	☐	☐	☐	☐

Current symptoms

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

1 = Mild, 2 = Moderate, 3 = Severe

Complaint	■	#
Coughing	☐	
Wheezing	☐	
Chest tightness	☐	
Exercise induced asthma	☐	
Frequent colds	☐	
Breathlessness at rest	☐	
Frequent sighs	☐	
Frequent yawning	☐	
Feeling short of breath	☐	
Palpitations	☐	
Erratic / faster heart beat	☐	
Sleep apnoea	☐	
Snoring	☐	
Faster or deeper breathing	☐	
Visual disturbances	☐	
Chest wall pains	☐	
Feeling tense	☐	
Loss of Memory	☐	
Fear without reason	☐	
Dryness in mouth	☐	
Allergies	☐	
Dryness of skin	☐	
Breathing through mouth	☐	
Restless legs	☐	
Excessive mucus production	☐	
Tingling in the hands & fingers	☐	
Depression	☐	
Hay fever	☐	
Teeth grinding	☐	

Complaint	■	#
Excessive sweating	☐	
Cold hands / feet	☐	
Tummy upset / IBS	☐	
Aching muscles	☐	
Tiredness	☐	
Insomnia / broken sleep	☐	
Nightmares	☐	
Poor concentration	☐	
Racing mind	☐	
High perceived stress	☐	
Feeling of anxiety	☐	
Panic attacks	☐	
Headaches	☐	
Light headedness	☐	
Go to bathroom during night	☐	
Bloated feelings in stomach	☐	
Unable to breathe deeply	☐	
Irritability	☐	
Impotence	☐	
Wake unrefreshed	☐	
Pains in heart region	☐	
Diarrhoea	☐	
Breathing without pause after exhaling	☐	
Cramping	☐	
Excessing sneezing	☐	
Frequent urination	☐	
Runny nose	☐	
Reflux	☐	
Daytime sleepiness	☐	

Current illnesses and medication

Please list **Asthma medications** you take:

Preventer		Daily dose	
Reliever		Daily dose	

Other Illness	Medication	Daily dose

For female participants

Are you currently pregnant? YES ☐ NO ☐

Medical history

Have you suffered from any of the following and how do you rate the severity of your condition?

1 = Moderate, 2 = Severe, 3 = Very Severe

Condition	■	#
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	☐	
Fibromyalgia	☐	
Heart condition	☐	

Condition	■	#
High Blood Pressure	☐	
Hypoglycaemia	☐	
Low Blood Pressure	☐	
Kidney Disease	☐	
Migraine Headaches	☐	
Multiple Sclerosis	☐	
Nasal Polyps	☐	
Schizophrenia	☐	
Sleep Apnoea	☐	
Snoring	☐	
Stress	☐	
Tongue Tie	☐	
Other -	☐	
Specify:		

Date of most recent hospitalisation? _____

How did you hear about us?

Social media ☐ GP or consultant ☐ Health care practitioner ☐

Friend ☐ Internet search ☐ Other ☐

If other, please specify:

D I S C L A I M E R

Please read the following carefully and follow the instructions.

I, _____ agree not to decrease or alter my medication or
Please enter your full name
prescribed treatment without prior consultation and approval from a Medical Doctor.

- ☐ I confirm that I have read and fully understand that failing to comply with this direction may pose a risk to my health and that it would be against the recommendation of Paul Rodriguez
- ☐ I understand that each **Mindful Buteyko Breathing Consultation** consists of teaching and practical demonstrations in breathing retraining and does not constitute medical treatment or advice
- ☐ I agree not to teach other individuals following attending a **Mindful Buteyko Breathing Consultation.**

_____ Date: _____
Please enter your full name

Form completed by parent or guardian if applicant is under 18 years

Please enrol me in a **Mindful Buteyko Breathing Consultation**
at a cost of **$125** per session of up to 75 minutes duration and
payable to Learn to Sleep Well upon receipt of invoice
and commencing on a date(s) to be arranged

Please post to:
Learn to Sleep Well
PO Box 367 Altona VIC 3018
or scan and email to: paul@learntosleepwell.com