Learn to SleepWell

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

ENROLMENT FORM

Mindful Buteyko Breathing Course

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 currently use a **Mandibular Splint** or **other oral device**? 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		

Please indicate any other common symptoms that you may experience:

Current illnesses and medication

Please list **Asthma medications** you take:

Preventer		Daily dose	
Reliever		Daily dose	

List any **other illness** you have:

Illness	Medication	Daily dose

Other concerns

Please indicate if you have any concerns:

For female participants

Are you currently pregnant? YES ☐ NO ☐

How did you hear about this course?

Social media ☐ GP or consultant ☐ Health care practitioner ☐

Friend ☐ Internet search ☐ Other ☐

Newspaper ☐ Radio ☐ Specify: _____

Medical history

Do you now or have you ever suffered from any of the following and how do you rate the severity of your condition? (Please indicate as applicable)

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		
Heart Condition		

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

Age originally **diagnosed:**

Regularity of your symptoms:

Known **allergies to drugs**

What is your most **severe health problem?**

Date of most recent hospitalisation? _____

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 without

Please enter your full name

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 the **Mindful Buteyko Breathing Course** is a series of lectures and practical demonstrations in breathing retraining and does not constitute medical treatment or advice
- ☐ I am aware that I should keep my medication with me always
- ☐ I agree to only modify prescribed medications and treatments after consultation with a medical doctor
- ☐ I agree not to teach other individuals following commencement of the **Mindful Buteyko Breathing Course.**

_____ Date: _____

Please enter your full name

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

PAY NOW

Please enrol me in the **Mindful Buteyko Breathing Course** at a cost of **$695** payable to Learn to Sleep Well commencing on a date to be arranged.

Please post to:

Learn to Sleep Well

PO Box 367 Altona VIC 3018

or email to: paul@learntosleepwell.com