# COURSE ENROLMENT

Please enroll me in the Buteyko Course commencing

**/ /202** and please charge a deposit of AU$200 to my credit card (as below).

**Total course fee:**  **AU$995**

**Card type:** (please tick) **Visa** **Mastercard**

**Card Number:**

**Valid to:**  / **Amount paid** **AU**$……

Cardholder name…………………………………………..

Cardholder signature……………………………………...

Please email this form to [*paul@buteykoairways.com.au*](mailto:paul@buteykoairways.com.au) or post to:

***Buteyko Health & Breathing***

***PO Box 2409, Fitzroy, VIC 3065***

I understand that the Buteyko Institute Method (BIM) course is a series of lectures and practical demonstrations in breathing training and does not constitute medical treatment or advice. I am aware that my medication should be kept handy at all times. I agree to only modify prescribed medications and treatments after consultation with a medical doctor. I agree not to attempt to teach the BIM to other individuals.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

(signed by parent or guardian if under 18 years)

# PARTICIPANT DETAILS

First Name ………………………………………………….

Surname ………………………………………….…………..

Telephone ………. …………………………………………..

Email…………………………………………………………..

Suburb…………… …………………………………………...

Postcode………… …………………………………………...

Gender…………… …………………………………………..

Year of Birth……………………………….. ………………....

Occupation……………………………………………………

**Medical History to Date** (Major illnesses & operations)

………………………………………………………………………………………………………………………………………………………………………………………………………

………………………………………………………………………………………………………………………………………………………………………………………………………

………………………………………………………………………………………………………………………………………………………………………………………………………

**Have you had a sleep study?** *Yes No*

**Do you currently use a CPAP machine?** *Yes No*

**When did you commence CPAP therapy?** …………….

**Have you previously used a CPAP?** *Yes No*

**If you answered *Yes*, why did you stop using CPAP?** ……………………………………………………………………………………………………………………………………

**Do you currently use a mandibular splint or other oral device?** *Yes No*

…………………………………………………………………

CURRENT MEDICATION

*Please tick medications being taken and specify others not listed (including non-respiratory medications).*

**Nebuliser** Approximate minutes used …………

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Dosage** | **am** | **pm** |
| Ventolin |  |  |  |
| Atrovent |  |  |  |

**Respiratory Medications**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Dosage** | **am** | **pm** |
| Ventolin |  |  |  |
| Bricanyl |  |  |  |
| Asmol |  |  |  |
| Atrovent |  |  |  |
| Qvar |  |  |  |
| Pulmicort |  |  |  |
| Flixotide |  |  |  |
| Alvesco |  |  |  |
| Intal |  |  |  |
| Spiriva |  |  |  |
| Serevent |  |  |  |
| Oxis |  |  |  |
| Seretide |  |  |  |
| Symbicort |  |  |  |
| Prednisolone |  |  |  |
| Singulair |  |  |  |

Other (Please specify) …………………………………

**Other Medications**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Dosage** | **am** | **pm** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

HEALTH BACKGROUND

**Do you now or have you ever suffered from:** *Please tick as appropriate.*

1. Arthritis
2. Asthma
3. Attention Deficit Disorder
4. Anxiety
5. Bi-polar Disorder
6. Bronchiectasis
7. Bronchitis
8. Chronic Fatigue Syndrome
9. Cystic Fibrosis
10. Diabetes Type 1/Type 2
11. Emphysema/COAD/COPD
12. Epilepsy
13. Eczema
14. Heart condition
15. High Blood Pressure
16. Hi Cholesterol
17. Hypoglycaemia
18. Insomnia
19. Low Blood Pressure
20. Kidney disease
21. Migraine headaches
22. Multiple Sclerosis
23. Nasal Polyps
24. Schizophrenia
25. Psoriasis
26. Sleep Apnoea
27. Snoring
28. Thyroid Disorder
29. Other (Please specify)…………………………….

How do you rate the severity of your main condition?

1. Moderate Severe Very Severe

Age originally diagnosed ………

Regularity of your symptoms

……………………………………………………………

Known allergies to drugs………………….

……………………………………………………………

What is your most severe health problem? ………………………………………………………....

Date of most recent hospitalisation …………………….

**Females only -** Are you pregnant? Yes / No

**Name of Medical Practitioner** (optional)

………………………………………………………….…..

**Name of Specialist** (optional)

……………………………………………………….....….

**Symptoms suffered prior to starting the Buteyko Course (***Please tick.)*

1. Headaches
2. Dizziness
3. Ringing or buzzing in ears
4. Loss of memory
5. Mental fatigue
6. Restless sleep
7. Irritability
8. Lack of concentration
9. Stress
10. Fear without reason
11. Apathy
12. Coughing
13. Loss of feeling in the limbs
14. Impotence
15. Dryness in the mouth
16. Deterioration of vision
17. Loss of smell
18. Allergies
19. Pains in the heart region
20. Painful & irregular menstrual periods
21. Itching
22. Muscle pains
23. Dryness of skin
24. Diarrhoea
25. Shortness of breath
26. Breathing through mouth
27. Frequent deep breaths
28. Breathing without pause after exhaling
29. Tightness around chest
30. Short temper
31. Rhinitis
32. Trembling & tic
33. Deterioration of hearing
34. Prone to colds and/or flu
35. Flashes before the eyes
36. Shuddering in sleep
37. Restless legs
38. Cramping
39. Frigidity
40. Chest pains (not in heart region)
41. Weight gains
42. Weight loss
43. Bleeding veins
44. Sudden chilling of limbs & other parts
45. Varicose veins
46. Sudden physical exhaustion
47. Pains in the bones
48. Anemia
49. Excessive mucus production
50. Excessive sighing
51. Excessive sneezing
52. Excessive yawning
53. Muscular spasms
54. Palpitations
55. Sinusitis
56. Tachycardia
57. Loss of consciousness
58. Tingling in the hands & fingers
59. Dysphagia (difficulty in swallowing)
60. Grinding of teeth
61. Constipation
62. Haemorrhoids
63. Frequent urination
64. Abdominal bloating
65. Fatigue
66. Depression
67. Root canal therapy
68. Nose bleeds
69. Runny nose
70. Blocked Nose
71. Hay fever
72. Conjunctivitis
73. Indigestion
74. Reflux
75. Other (Please specify) ……………………………..