

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

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent’s name (if you are a minor) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Occupation or special interest (that you do a lot):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
 **Does your occupation or special interest require much TALKING or PHYSICAL EXERCISE?   
  
Physical exercise** NONE SOME MEDIUM-AMOUNT ALOT(circle applicable) **Talking** NONE SOME MEDIUM-AMOUNT ALOT (circle applicable)

Please give additional details if appropriate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Gender that you identify as and your pronouns:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you have any conditions/symptoms?** If so please list them 1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_3) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
4) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**When were you first diagnosed, or did you notice this condition/s**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
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**Please state which best describes your condition/s:**

Sometimes have symptoms: **□** Continuous symptoms (mild): **□**

Continuous Symptoms (moderate): **□** Continuous symptoms (severe): **□**

**Have you ever been admitted to the hospital for asthma attacks/or other, in the past four years**? If so please give a description of frequency.  
   
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
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**Do you think you tend to breathe deeply (with diaphragm) or shallow (upper chest)?**

1 2 3 4 5 6 7 8 9 10 (circle applicable)

Deeply Shallow  
  
**Please circle your answer to the following questions:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Do you feel stressed or anxious?** | **Never** | **Sometimes** | **Often** | **Very Often** |
| **Is your nose blocked?** | **Never** | **Sometimes** | **Often** | **Very Often** |
| **Do you breathe through your mouth during the day?** | **Never** | **Sometimes** | **Often** | **Very Often** |
| **Do you breathe through your mouth during the night?** | **Never** | **Sometimes** | **Often** | **Very Often** |
| **Do you wake up with a dry mouth?** | **Never** | **Sometimes** | **Often** | **Very Often** |
| **Do you breathe through your mouth when you exercise?** | **Never** | **Sometimes** | **Often** | **Very Often** |

**Have you completed a Sleep Study?** YES / NO (circle applicable)  
  
If yes, give approximate date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If so, what was the outcome/diagnosis?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
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**Do you have high blood pressure?** YES / NO

**Have you been prescribed a CPAP machine?** YES / NO (circle applicable)

**Do you currently use it?** NA / YES / NO (circle applicable)

**Do you Smoke or Vape?** YES / NO (circle applicable)

**IF yes, how many cigarettes or time spent vaping a day:** \_\_\_\_\_\_\_\_

**How many glasses of water do you drink each day (approx.)?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you ever limited your intake of dairy foods?** YES / NO (circle applicable)

**If yes has this helped you with your breathing?** NA / YES / NO (circle applicable)

**Have you been diagnosed with a tongue tie** YES / NO (circle applicable)

**If yes, have you had it released?** NA / YES /NO (circle applicable)  
  
and if so, what date was the release done on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
**Have you ever done Myofunctional Therapy?** YES /NO is so with whom \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and   
  
When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Exercise**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| How many hours a week do you partake in physical exercise? | Less than one hour | 1-2 hours | 2-3 hours | 3-4 hours | 4-5 hours | 5-6 hours | 6-7 hours | 7 or more |

**What type of exercise does it tend to be?  
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
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**Please indicate √ the level of severity of any of the symptoms that you experience in the list below. For symptoms you do not have please leave blank:**

**1 = Mild, 2 = Moderate, 3 = Severe**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Complaint** | **1** | **2** | **3** |  | **Complaint** | **1** | **2** | **3** |
| Coughing |  |  |  |  | Poor Concentration |  |  |  |
| Wheezing |  |  |  |  | Tiredness or exhaustion |  |  |  |
| Exercise-Induced Asthma |  |  |  |  | Worrying or apprehension |  |  |  |
| Asthma |  |  |  |  | High Perceived Stress |  |  |  |
| Breathlessness at rest |  |  |  |  | Panic Attacks |  |  |  |
| Breathlessness w light exercise |  |  |  |  | Depression |  |  |  |
| Frequent Yawning |  |  |  |  | Tummy upset / aches / IBS |  |  |  |
| Frequent Sighs |  |  |  |  | Achy Muscles |  |  |  |
| Fast breathing |  |  |  |  | Sore muscle after working out |  |  |  |
| Breathing 1/2 during a sentence |  |  |  |  | Feeling of weakness in muscles |  |  |  |
| Blocked nose |  |  |  |  | Excessive sweating |  |  |  |
| Insomnia |  |  |  |  | Frequent Sweaty palms |  |  |  |
| Waking up at night to pee |  |  |  |  | Chest tightness |  |  |  |
| Sleep Apnoea |  |  |  |  | Racing heart |  |  |  |
| Nightmares |  |  |  |  | Lightheaded or dizzy |  |  |  |
| Bed wetting at night |  |  |  |  | Heart pounding in your chest |  |  |  |
| Frequently waking at night |  |  |  |  | Skipping/irregular heartbeat |  |  |  |
| Waking because of a gasp |  |  |  |  | Vertigo |  |  |  |
| Waking up with a dry mouth |  |  |  |  | Frequent Cold hands and or feet |  |  |  |
| Headaches at waking |  |  |  |  | Constipation |  |  |  |
| Headaches during the daytime |  |  |  |  | Increased need to pee during day |  |  |  |
| Trouble remembering things |  |  |  |  | Frequent Colds |  |  |  |

**Nijmegen Questionnaire: Please indicate √ the level of severity of any of the symptoms that you experience in list below:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Complaint** | **Never**  **0** | **Rarely**  **1** | **Sometimes**  **2** | **Often**  **3** | **Very often**  **4** |
| Chest Wall Pains |  |  |  |  |  |
| Feeling Tense |  |  |  |  |  |
| Blurred vision |  |  |  |  |  |
| Dizzy Spells |  |  |  |  |  |
| Confusion, losing contact with reality |  |  |  |  |  |
| Fast or deep breathing |  |  |  |  |  |
| Shortness of breath |  |  |  |  |  |
| Tightness in the chest |  |  |  |  |  |
| Bloated Feelings in Stomach |  |  |  |  |  |
| Tingling of fingers |  |  |  |  |  |
| Unable to Breathe Deeply |  |  |  |  |  |
| Stiffness in fingers or arms |  |  |  |  |  |
| Stiffness around the mouth |  |  |  |  |  |
| Cold hands or feet |  |  |  |  |  |
| The thumping of the heart |  |  |  |  |  |
| Feeling of anxiety |  |  |  |  |  |
| **Total:** |  |  |  |  |  |

**Please indicate any other common symptoms that you may experience that we have not mentioned here:**

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

**If you have Asthma, please list the Asthma medications you take:**

Preventer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Daily Dose:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reliever: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Daily Dose:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List any other illness you have mentioned or not mentioned in the questionnaire that you take medication for**  
Illness/condition \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ medication\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
Illness/condition \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ medication\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
Illness/condition \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ medication\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
Illness/condition \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ medication\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
Illness/condition \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ medication\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please indicate if you have any concerns, you have about taking this Buteyko workshop series:**

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

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**Please indicate if you have any access questions or access accommodation that will help you feel comfortable in this course and/or help you benefit from the course.**

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

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**Pregnancy**: Please tell the practitioner if you are currently pregnant and if so at what stage of pregnancy are you (months)  
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Informed Consent**Kathleen graduated as a teacher of the Buteyko Method in 2022 through training with Patrick McKeown.   
  
In this course Kathleen will teach and describe:

* Mouth taping. **Part of the Buteyko Method**
* Breathing exercises that teach participants to breathe **Light** (low volume with ease), **Slow,** and **Deeply** (with Diaphragm). **Part of the Buteyko Method**
* Breathing exercises that expose you to tolerable air hunger. Air hunger is a feeling of needing the breath more air. **Part of the Buteyko Method.**
* Strategizing how to condition the nose to enable a shift to predominantly nose breathing. **Part of the Buteyko Method.**
* Movement, alignment, and strengthening exercises that work to strengthen the deep frontline with the aim to improve tongue strength and oral posture. **Part of Kathleen’s study and practice of functional movement and the Axis Syllabus.**

All participants are led to do these exercises at their own pace and within a reasonable comfort level.

The Moving Breath Project does not diagnose, treat, or cure any disease or condition. No claims are made by the Moving Breath Project as to specific health benefits that will result from taking our workshops. Please refer to this page on the Buteyko website to see studies that indicate possible effects the Buteyko Method may have: [Conditions - Buteyko Clinic](https://buteykoclinic.com/library/).

Individuals should consult a qualified health care provider for medical advice if they feel they need to prior to participation, or if Kathleen requests. Participants assume all responsibility and risk for the use of the information taught in our workshops.

Also please note participants will often need to put in significant and ongoing hours of work to see the most effects. Those that find a way to incorporate the Buteyko Method as part of their daily living are often the ones that see the most positive effects.

**How did you hear about this course:** (Please circle)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Social Media | Friend | Newspaper | GP or Consultant | Internet Search | Radio | Health Care Practitioner | Other: |

**Disclaimer:** you are requested to read the following carefully and to follow the instructions.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ agree to seek medical consult prior to starting the workshop should Kathleen ask me to. I agree not to decrease or alter my medication without prior consultation and approval from a Medical Doctor even if my symptoms abate or disappear. 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 recommendations of Kathleen Rea.   
  
I have been formed of the nature of the course and agree to participate.  
  
Name (printed) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

In the event of a participant is under 18 years of age, this disclaimer must be signed by a parent or legal guardian.  
  
  
Email filled out form to [kathleenrea@outlook.com](mailto:kathleenrea@outlook.com) with “Buteyko Questionnaire” and your name in the email subject line