BUTEYKO CLINIC INTERNATIONAL
Accredited by Prof. KP Buteyko

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? _____

_____

_____

_____

Please state which best describes your condition/s:

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

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

This questionnaire was compiled by Kathleen Rea in 2022 and is based upon Patrick McKeown's Screening Form created in 2016 and available through the Buteyko Clinic International training program.

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.

_____

_____

_____

_____

_____

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			

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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_____

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

_____

_____

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.

_____

_____

_____

_____

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.

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 with “Buteyko Questionnaire” and your name in the email subject line

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