Please complete the questions below as accurately as possible so that your practitioner can ensure the workshop is suitable for your individual condition.

Name: ______________________________________ Contact Number: ________________________________

Parent's name (if applicable) ___________________ Email address: __________________________________

Occupation: ______________________ Does it require much TALKING or PHYSICAL EXERCISE? (Circle)

Please give additional details if appropriate: ____

What condition / symptoms do you have? 1) ___________________________2) ____________________

When were you first diagnosed with your condition? __________________ (years)

Please state which best describes your condition:

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

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

How often have you been admitted to hospital for asthma attacks/or other, in the past three years? ________

Do you feel that deep breathing is good for you? YES / NO

Please circle answer:

Do you feel stressed, anxious regarding your condition?	**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? (Do you wake up with a dry mouth?)	**Never**	**Sometimes**	**Often**	**Very Often**

Have you completed a Sleep Study? YES / NO If yes, give approximate date: ______________

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 glasses of pure water do you drink each day (approx.)? ___________________

Do you limit your intake of dairy foods? YES /NO Has this helped you? YES / NO

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

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

1 = Mild, 2 = Moderate, 3 = Severe

Complaint	**1**	**2**	**3**		**Complaint**	**1**	**2**	**3**
Coughing					Excessive sweating			
Wheezing					High Perceived Stress			
Exercise Induced Asthma					Tummy upset / IBS			
Frequent Colds					Achy Muscles			
Breathlessness at rest					Tiredness			
Frequent Sighs					Insomnia /Broken Sleep			
Frequent Yawning					Poor Concentration			
Sleep Apnoea					Panic Attacks			
Snoring					Headaches			
Lower back pain								

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					
Thumping of the heart					
Feeling of anxiety					
Total:					

Please indicate any other common symptoms that you may experience: ________________________________

Please list Asthma medications you take:

Preventer: ____ Daily Dose:_____________________

Reliever: ____ Daily Dose:_____________________

List any other illness you have: __________________________________ Medication:_________________________

Please indicate if you have any concerns: ____

____

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

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

For Female participants: Please tell the practitioner if you are currently pregnant.

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

I,_____________________________ agree not to decrease or alter my medication 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 recommendations of H Dick.

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.