

**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 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 Patrick McKeown.

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.