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www.breathebetterperformbetter.com

BREATHE BETTER,
PERFORM BETTER

Please complete the questions below as accurately as possible so that I can assist you with your individual conditions.

Name:_____ **Contact Number:**_____

Email Address: _____ **Occupation:**_____

Does your occupation require much TALKING and/or PHYSICAL EXERCISE? (circle)

Main Complaint: _____

When did it start? _____ INTERMITTENT or CONTIUOUS? (circle)

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?: _____ For how many years?: _____

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

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Have you ever been diagnosed with any of the following? (circle all that apply):

Asthma	COPD	High Blood Pressure	Sleep Apnea: Central, Obstructive, Mixed
ADD/ADHD	Anxiety	Depression	Panic Attacks
Pulmonary Hypertension		Rheumatoid Arthritis	Osteoarthritis
COVID-19		Long-term COVID	Diabetes Mellitus— Type 1 or Type 2

Other: _____

Medications (please list all):

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please place a check mark indicating the level of severity for any of the following symptoms you experience:

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			
Excessive Yawning					Poor Concentration			
Sleep Apnea					Panic Attacks			
Snoring					Headaches			
Lower back pain					Feeling tense			
Cold sensitivity in hands or feet					Breathing through your mouth at night			

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Nijmegen Questionnaire

Please place a check mark indicating the level of severity for any of the following symptoms you experience:

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:

_____

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Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?

This refers to your usual way of life in recent times.

Even if you haven't done some of the things recently, try to work out how they would have affected you.

Use the following scale to choose the **most appropriate number** for each situation:

0 = would **never** doze
1 = **slight chance** of dozing
2 = **moderate chance** of dozing
3 = **high chance** of dozing off

It is important that you answer each question as best as you can.

Situation	**Chance of Dozing (0-3)**
Sitting and reading	_____
Watching TV	_____
Sitting, inactive, in a public place (e.g. a theatre or a meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____

STOP-BANG Questionnaire

The STOP-BANG questionnaire is used to screen for Obstructive Sleep Apnea (OSA) and assesses if you are at low, moderate, or high risk for Sleep Apnea.

Please answer **Yes** or **No** to the following questions:

	Yes	**No**
Do you snore loudly? Loud enough to be heard through closed doors.		
Do you often feel tired, fatigued, or sleepy during the daytime?		
Has anyone observed you stop breathing during your sleep?		
Do you or are you being treated for high blood pressure?		
Is your Body Mass Index (BMI) more than 35?		

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Are you older than 50 years of age?		
Is your neck size large? (Males > 17"; Females > 16")		
Are you male?		
Total Score:		

Yes to <2 questions: Low Risk

Yes to 3-4 questions: Moderate Risk

Yes to >5 questions: High Risk

If you have answered and found that you are at moderate or high risk, consult your doctor to see if you need to investigate further. The Epworth Sleepiness Scale can also be used to further determine the necessity for a Sleep Study.

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 Michael Lansing.

Signature: Date:

In the event of a participant is under 18 years of age, this disclaimer must be signed by a parent or legal guardian.

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Release of Claims, Assumption of Risk and Indemnification

By signing this form you will be agreeing to certain restrictions on your legal rights. Please read it carefully before signing. Please feel free to consult with your own attorney before signing.

Initial Each Box	
	I understand that the instructor teaching me Technique is not acting as a medical practitioner.
	If at any time during this course, I have any concerns about my health or well-being, I agree to notify my course instructor immediately. I understand that I am free to leave the course at any time for any reason. If during the course or at any time after this course, I feel the need for any assistance, medical or otherwise, I take full responsibility for communicating this as well as for seeking appropriate care including leaving the course and obtaining such appropriate care.
	If I am a female, I will ensure I am not pregnant before starting and during the Technique training and exercises. If I am pregnant, I will discuss this with my Oxygen Advantage instructor prior to starting the course and exercises. If I become pregnant or believe I may be pregnant while taking this training, I will stop all Technique exercises and inform my Oxygen Advantage instructor immediately.

_____ _____ _____

Signature Print Name Legibly Date

Parent or legal guardian's signature is required below for participants under the age of 18.

_____ _____ _____

Signature Print Name Legibly Date