REGISTRATION FORM

PLEASE FILL IN ALL THE INFORMATION ON EACH OF THE THREE PAGES:

Name: _____
Address: _____
_____
Telephone: work _____ home _____Mob _____
Email: _____
Occupation:_____
Course date:_____
Emergency contact: _____Relationship_____
Telephone_____

MEDICAL HISTORY
Type of Illness: (e.g. Asthma)_____
Degree: (e.g. Mild) _____
Regularity of attacks or problems: _____
Age originally diagnosed: _____ Current age: _____
Medical practitioner: _____ Telephone: _____
Address_____
Last time hospitalized for breathing problem: _____
For another condition:_____
Date you last took cortisone orally or by injection (eg Prednisone, Prednisolone, Methylprednisone):_____

Have you ever suffered from the following problems?:

Heart Condition	_____	High Blood Pressure	_____
Low Blood Pressure	_____	Epilepsy	_____
Diabetes	_____	Schizophrenia	_____
Kidney Disease	_____	Depression	_____
Under active Thyroid	_____	High Cholesterol	_____
Over active Thyroid	_____	Migraines	_____
Angina	_____	Fluid Retention	_____
Hypoglycaemia	_____	Other	_____

What drugs are you allergic to?
_____

_____

What other things besides drugs are you allergic to?
_____

_____

SYMPTOMS SUFFERED PRIOR TO COMMENCING COURSE

Please place check in space provided

( ) shortness of breath
( ) tightness around chest
( ) headaches
( ) dizziness
( ) loss of memory
( ) lack of concentration
( ) irritability
( ) ringing/buzzing in ear
( ) fear of sultry air
( ) coughing
( ) impotence
( ) far sightedness
( ) allergies
( ) asthma attacks
( ) itching
( ) dryness of skin
( ) loss of hearing
( ) flashes before eye
( ) snoring
( ) weight loss
( ) weight gain
( ) varicose veins
( ) pains in the bones
( ) diarrhea
( ) bleeding veins
( ) breathing through mouth
( ) frequent deep breaths
( ) breathing without pause
( ) insomnia
( ) mental fatigue
( ) short temper
( ) apathy
( ) fear without reason
( ) trembling and tic
( ) loss of feeling in limbs
( ) dryness in mouth
( ) deterioration of vision
( ) pains in heart region
( ) painful/irregular periods
( ) muscle pains
( ) rhinitis
( ) prone to colds/flu etc
( ) shuddering in sleep
( ) loss of libido
( ) chest pains (not heart)
( ) sudden chilling of limbs
( ) physical exhaustion
( ) anemia
( ) loss of smell
( ) frequent sighing
( ) any symptoms not listed

Please list other symptoms: _____

_____

What kind of physical exercise do you take?: _____

_____

How often?:_____

Please list all drugs you are currently taking, or have taken, in the past two months whether related to breathing difficulties or not. Please write clearly.

Medication (please print)	**Dosage: am. pm.**	**What do you take this for?**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Vitamins and supplements you take, how often, and for what condition: **Please write clearly**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

I understand that the Buteyko Method Breath Reconditioning Program is a series of lectures and training. It does not constitute medical treatment. Further more, I, the undersigned, agree only to modify prescribed medication after consultation with a medical doctor.
I also agree that, as I am not a trained Buteyko Practitioner, I will not attempt to teach other people without the written permission of Suzy Beach or another certified practitioner**.**

Name: _____

Date: _____

Signed: _____

If student is under 18 this form must be signed by a parent of guardian, and those under 16 must be accompanied to class by a parent or responsible adult.