

Pippa Kiraly
LIFELONG EASY BREATHING
BIBH Certified Buteyko Practitioner
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REGISTRATION FORM

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

Name: _____

Address: _____

Telephone: work _____ home _____ cell _____

Email: _____

Occupation: _____

Course date: _____

Next of Kin: _____ 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

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

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 Pippa Kiraly 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.

I enclose a check made out to Pippa Kiraly, Lifelong Easy Breathing, for _____
Mail this form with the check to the address at the top of the first page.