

Name:  
Sex  
Age  
Email:  
Tel:

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Tell us about your breathing: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medical conditions, e.g., cardiovascular?

Respiratory disorders, e.g., asthma?

Injuries, past and present, e.g. chest?

Physical complaints. e.g., headache?

Emotional conditions, e.g., panic?

Pregnancy experiences, current or previous?

Current prescriptions, e.g., depression?

Life traumas, e.g., abuse?

Pain experiences, past or present?

Physical limitations, e.g., fatigue?

Allergies and sensitivities, e.g., food?

Deficiencies, e.g., magnesium?

Relationship difficulties, e.g., marriage?

Work related challenges, e.g., social issues?

Learning issues, e.g., attention deficit?

Performance issues, e.g., anxiety?

Are you seeing a healthcare practitioner? If so, can we contact her (him)? Please provide contact information.

Other Comments \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_