

**Application to attend a course of instruction in the Buteyko Institute Method™  
conducted by Breath Connection of PO Box 1129 Busselton WA 6280.**

I ..... have satisfied myself that the Buteyko Institute Method™ offers me\*\* the possibility of improving my\*\* breathing and of eliminating or reducing symptoms of hyperventilation and incorrect breathing.

I understand that this is a course of instruction, coaching and support aimed at giving me the skills and understanding necessary to change my breathing habits and reset breathing patterns in the hope that this will lead to improved quality of my life.

I acknowledge that the course does not constitute medical treatment and that I am responsible for my personal health and for my relationship with the medical establishment including the use of prescribed medication and appliances.

I agree the Breath Connection can only be responsible for the quality of its instruction in the Buteyko Institute Method™ and not for my application or misapplication of the Method.

I understand that there will be daily “homework” during the initial 5 sessions and that this is an essential component of the course.

I understand that I will need to practice breath retraining exercises daily for an indefinite period, to integrate the practice into my daily life and to follow guidelines on food, drink, exercise and sleep in order to achieve optimum improvements to my breathing and consequent reduction or elimination of my symptoms of incorrect breathing.

I understand that continuation of the benefits of improved breathing will require ongoing monitoring of and attention to my breathing.

I undertake to be punctual for classes and to respect the privacy and confidentiality of other class members.

I agree to my Breath Connection Practitioner discussing confidential aspects of my history, symptoms, progress and medication with Trainee Practitioners in the course of their training.

I agree to being contacted by Breath Connection by phone, mail or email, as provided by me, regarding future courses, updates to training or information relevant to breathing.

I understand that the method taught to me is tailored to suit me and that completion of this course does not qualify me to teach the Buteyko Institute Method™.

The place of origin of this agreement is the State of Western Australia, Australia and it shall be governed in accordance with the laws of Western Australia. The courts of Western Australia shall be the forum for the resolution of any dispute arising hereunder.

\*\* includes dependent minors attending the course.

Location ..... Commencement date ...../...../.....

Preferred time: Morning, Afternoon or Evening (All options may not be available)

Signature ..... Date ...../...../ 201...

## Booking form for a Breath Connection course

Name ..... Age ..... Main problem.....

Additional 1.....

Additional 2.....

Additional 3.....

Additional 4.....

Address .....Phone .....

6 Month Program of introductory seminar, initial group instruction, follow-up and support.	Early Bird pre-paid in full.	Full Payment at start of course	3 month payment option			6 month payment option		
			Total cost	Deposit at start.	3 monthly payments	Total cost	Deposit at start.	6 monthly payments
Standard - Adult	850	900	945	300	215	980	200	130
Additional dependent family members.	425	450	480	150	110	490	100	65
Concession	700	750	790	250	180	830	200	105
Additional dependent family members - conc.	350	375	400	130	90	430	100	55

Introductory seminar where provided at start of course.	Booking deposit per person to secure a place if not prepaying.	Extra Manual if required for additional dependent family member.
Free	\$100	\$75

***Circle the amounts you are paying above. Use payment options below.***

**By cheque or money order** payable to Breath Connection.

**By Netbank transfer.**

Account Name: Breath Connection BSB 066 508 Account Number: 10241943 Ref. Your surname.

**By credit card – Eftpos available.**

**By credit card – written authorisation. (Multiple payments available)**

Credit card details: Mastercard Visa Amount \$.....

Name on Card .....

Number: \_ \_ \_ \_ \_ Expires ... /....

Signature ..... Date .... /..... / 201...

**By cash payment.** Notify your intention and bring to the class.

**By Bartercard.** Notify your intention and bring to the class.

Return to Breath Connection PO Box 1129 Busselton WA 6280  
Fax 08 9754 7070 Email: info@breathconnection.net

**CONFIDENTIAL**

**NOTHING TO BE DISCLOSED TO ANY  
THIRD PARTY WITHOUT EXPRESSED  
PERMISSION OF THE CLIENT**



## Pre-course Assessment & Client Information

First Name:	<input type="text"/>		
Surname:	<input type="text"/>		
Address:	<input type="text"/>		
Suburb:	<input type="text"/>		
State:	<input type="text"/>	P/code:	<input type="text"/>
Telephone ( home )	<input type="text"/>		
Telephone ( business )	<input type="text"/>		
Facsimile:	<input type="text"/>		
Mobile:	<input type="text"/>		
e-mail:	<input type="text"/>		
Male/Female	<input type="text"/>	Date of birth:	<input type="text"/>
Occupation:	<input type="text"/>		
Name of Health Fund:	<input type="text"/>		
What is your most severe health problem or symptom?			
<input type="text"/>			
<input type="text"/>			
Regularity of Symptoms:	<input type="text"/>		
Degree of Condition:	<input type="text"/>		
Medical Practitioner	<input type="text"/>		
Specialist	<input type="text"/>		
What was the deciding factor that led you to start our course?			
<input type="text"/>			
Where did you hear about us? <input type="text"/>			
Name of the person who referred or recommended us to you:			
<input type="text"/>			



## Have you ever suffered from?

List age first diagnosed on left hand side and place an X in the appropriate box M=Mild, S=Severe, VS=Very Severe

	M	S	VS	Office use
<input type="checkbox"/> Asthma				
<input type="checkbox"/> Allergies				
<input type="checkbox"/> Bronchitis				
<input type="checkbox"/> Eczema				
<input type="checkbox"/> Hay fever				
<input type="checkbox"/> Pleurisy				
<input type="checkbox"/> Pneumonia				
<input type="checkbox"/> Bronchiectasis				
<input type="checkbox"/> Cystic Fibrosis				
<input type="checkbox"/> Emphysema				
<input type="checkbox"/> COAD or COPD				
<input type="checkbox"/> Fibrosing Alveolitis				
<input type="checkbox"/> Sleep Apnoea				
<input type="checkbox"/> Chronic Fatigue Syndrome				
<input type="checkbox"/> Fibromyalgia				
<input type="checkbox"/> Post Viral Fatigue				
<input type="checkbox"/> Low Blood Pressure				
<input type="checkbox"/> Ross River Virus				
<input type="checkbox"/> Lyme Disease				
<input type="checkbox"/> Glandular Fever				
<input type="checkbox"/> Anaemia				
<input type="checkbox"/> Multiple Sclerosis				
<input type="checkbox"/> Attention Deficit Disorder				
<input type="checkbox"/> Arthritis				
<input type="checkbox"/> Cancer				
<input type="checkbox"/> Leukemia				
<input type="checkbox"/> Diabetes				
<input type="checkbox"/> Hypoglycaemia				
<input type="checkbox"/> Epilepsy				
<input type="checkbox"/> Heart Condition				
<input type="checkbox"/> Angina				
<input type="checkbox"/> High Blood Pressure				
<input type="checkbox"/> Tinnitus				
<input type="checkbox"/> Gout				
<input type="checkbox"/> Irritable Bowel Syndrome				
<input type="checkbox"/> Endometriosis				
<input type="checkbox"/> Kidney Disease				
<input type="checkbox"/> Schizophrenia				
<input type="checkbox"/> Depression				
<input type="checkbox"/> Stress				
<input type="checkbox"/> Anxiety				
<input type="checkbox"/> Phobias				
<input type="checkbox"/> Insomnia				
<input type="checkbox"/> Migraine Headaches				
<input type="checkbox"/> Parkinsons Disease				
<input type="checkbox"/> Other _____				

## Medical History and other information

Have you had your tonsils removed & when?  
\_\_\_\_\_

Have you had your appendix removed & when?  
\_\_\_\_\_

Do you wear glasses or contacts & when?  
\_\_\_\_\_

Have you had any other major operations (please list)?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Average hours sleep per night \_\_\_\_\_

Average number of wakes per night? \_\_\_\_\_

Current weight kg's \_\_\_\_\_

Desired Weight \_\_\_\_\_

Latest Blood Pressure reading \_\_\_\_\_

Have you had any major car accidents (please list)?  
\_\_\_\_\_  
\_\_\_\_\_

Date of most recent hospitalisation and reason?  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever broken any bones? (please list)  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any known allergies to drugs?  
\_\_\_\_\_  
\_\_\_\_\_

Others Consulted (eg Chiro, Physio, Naturopath etc)  
\_\_\_\_\_  
\_\_\_\_\_

Other Relevant information:  
\_\_\_\_\_  
\_\_\_\_\_

Blood group if known     O     A     A1     A2     B     AB



