OXYGEN ADVANTAGE®
BY PATRICK MCKEOWN

Name: ____________________________________ **Contact Number:** ______________________________

Email address: ____________________________________

Occupation: ________________________ Does it require much TALKING or PHYSICAL EXERCISE? (Circle if applicable)

Please give additional details if appropriate: ____

____

Please circle answer:

Are you stressed during the day?	**Never**	**Sometimes**	**Often**	**Very Often**
Do you experience cold hands or feet?	**Never**	**Sometimes**	**Often**	**Very Often**
Do you notice yourself yawning regularly 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**
What is your BOLT score? Exhale through nose. Pinch nose with fingers and count how many seconds until first definite desire to breathe. (Wait 3-5 minutes between trial).	**Trial #1**		**Trial #2**	

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

Please indicate √ the level of severity of any of the symptoms that you experience in list below:

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			
Frequent Yawning					Poor Concentration			
Sleep Apnoea					Panic Attacks			
Snoring					Headaches			
Lower back pain								

1 Questionnaire compiled by Patrick McKeown 2018

Nijmegen Questionnaire

Please indicate √ the level of severity of any of the symptoms that you experience in list below:

Complaint	Never 0	Rarely 1	Sometimes 2	Often 3	Very often 4		Complaint	Never 0	Rarely 1	Sometimes 2	Often 3	Very often 4
Chest Wall Pains							Bloated Feelings in Stomach					
Feeling Tense							Tingling of fingers					
Blurred vision							Unable to Breathe Deeply					
Dizzy Spells							Stiffness in fingers or arms					
Confusion, losing contact with reality							Stiffness around the mouth					
Fast or deep breathing							Cold hands or feet					
Shortness of breath							Thumping of the heart					
Tightness in the chest							Anxiety					
Total							**Total**					

Total Overall Score: _____ (A score of over 23 out of 64 suggests a positive diagnosis of hyperventilation syndrome)

Please indicate any other common symptoms/condition that you may experience:

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How did you hear about this course: (Please circle)

Social Media	Friend	OxygenAdvantage.com	Internet Search	Radio	Health Care Practitioner	Other:

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 the Technique is not a medical practitioner or knowledgeable in prescribing medication.
	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 Research Institute Ltd instructor immediately.

______________________________ ________________________________ Date: ____/____/______

Signature Print Name Legibly

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

______________________________ ________________________________ Date: ____/____/______

Signature Print Legal Name Legibly