YOUR BREATHING HABITS

Everyone has breathing habits. Most people are NOT aware of their breathing habits and how they may be interacting with other complaints, symptoms, and deficits. This checklist has been designed to serve as a "guideline" for assisting you in exploring whether or not your breathing habits are consistent with optimal respiration, and if not, how they may be affecting you at specific times and places.

Name _____ Date_____ Email _____

Tel _____ Sex ____ Age ____ Primary health issue? _____

Is there a breathing issue? _____

Answers to the following questions are important to learning about the possible origins of your breathing habits.

☑ YES ☐ NO Issues related to breathing? _____
☐ YES ☐ NO Episodes of not being able to get enough air? _____
☐ YES ☐ NO Respiratory disorders? _____
☐ YES ☐ NO Physical injuries: e.g., back, chest, neck? _____
☑ YES ☐ NO Emotional issues: e.g., panic, anxiety, anger? _____
☐ YES ☐ NO Life traumas: e.g., PTSD, emotional abuse, chronic stress? _____
☑ YES ☐ NO Pain issues: past or present, acute or chronic? _____
☐ YES ☐ NO Physical limitations: e.g., fatigue, speech, movement? _____
☐ YES ☐ NO Deficiencies: e.g., electrolytes (kidney problems)? _____
☐ YES ☐ NO Social challenges: e.g., relationships, family? _____
☐ YES ☐ NO Work related challenges: e.g., co-workers, supervisor? _____
☐ YES ☐ NO Learning issues, e.g., attention, memory, focus? _____
☐ YES ☐ NO Performance issues: e.g., speaking, technology, testing _____
☐ YES ☐ NO Current prescriptions? _____

Do you ever experience any of the 14 symptoms listed below? Check the Y column for "YES," OR the N column for "NO," after each symptom listed. If you checked YES, indicate *how frequently you experience the symptom* by checking a number 1 through 7, where 1 is rarely and 7 is every day. Then enter in the *situations in which you experience a symptom*, in the "situation column," by entering a number that corresponds to one of the 15 situations listed at the bottom of the page. If the situation is not shown on the list, write it into the "comment" column. Focus on when, where, and with whom these symptoms may occur.

How often? 1 = rarely ..... 7 = every day

Do you experience the following? If so, how often?	*N*	*Y*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*Situations*	*Comment*
Chest tightness, pressure, or pain											
Intentional breathing, purposeful regulation											
Dizziness, light-headedness, fainting											
Shortness of breath, difficulty breathing											
Tingling or numbness, e.g., fingers, lips											
Unable to breathe deeply											
Not exhaling completely, aborting the exhale											
Deep breathing, like during talking											
Chest breathing, effortful breathing											
Breath holding, irregular breathing											
Rapid breathing, panicky breathing											
Worried about my breathing											
Mouth breathing											
Can't seem to get enough oxygen											

*SITUATIONS: circumstances under which you experience the above symptoms

(01) working (employment)
(02) resting (between tasks)
(03) performing (e.g., test taking)
(04) feeling anxious or worried
(05) feeling tired or stressed
(06) interacting in groups
(07) traveling, unfamiliar places
(08) socializing, meeting people
(09) feeling angry or upset
(10) intimacy, expressing feelings
(11) physical discomfort, pain
(12) going to sleep, while asleep
(13) learning new tasks, new info
(14) feeling unsure of self
(15) allergens, weather, foods

General comments:_____
_____

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