Forename_____ Surname_____ Date of birth_____

Email_____Tel:_____

Address_____

_____Post Code_____

Complete the tables below and return by email or post for our preliminary assessment of your breathing condition.

Give the importance or frequency of the following symptoms for you:

0- Never, 1- Rarely, 2-Often, 3- Very often or 4- Always a problem

Table 1 (Nijmegen Questionnaire)

Symptoms Experienced	0	1	2	3	4
Chest pain					
Blurred vision					
Dizziness					
Confusion or loss of touch with reality					
Fast or deep breathing					
Shortness of breath, breathlessness					
Tightness across chest					
Bloated sensation in stomach					
Tingling in fingers or hands					
Difficulty breathing or taking a deep breath					
Stiffness or cramps in fingers or hands					
Tightness around mouth					
Cold hands or feet					
Palpitations in chest					
Anxiety					
Totals					

Table 2

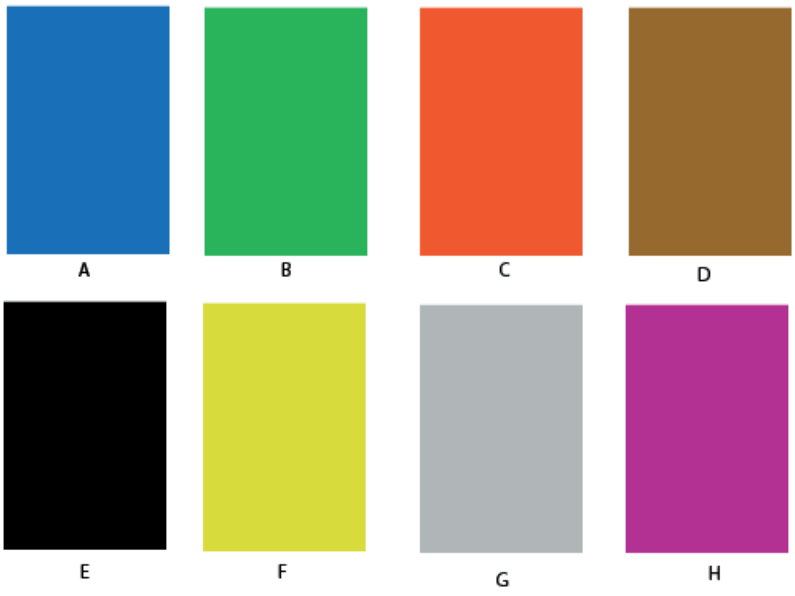
Symptoms Experienced	0	1	2	3	4
Upper chest breathing					
Erratic breathing patterns					
Fast or deep breathing					
Yawning or sighing					
Breathing through the mouth					
Airways are extra sensitive					
Coughing					
Allergies, rhinitis, hay fever					
Sneezing					
Blocked or runny nose					
Reduced sense of smell					
Dry mouth					
Dental or gum problems					
Repeated throat clearing					
Ringing in ears					
Totals					

Table 3

Symptoms Experienced	0	1	2	3	4
Light headed feeling					
Rapid heart beat					
High blood pressure					
Varicose veins					
Repeated cold, chest infections					
Prone to sickness					
Visual disturbances, flashes or shadows before eyes					
Poor concentration, mental fatigue, forgetful					
Irritable, short tempered					
Mild depression					
Frequent urination					
Nausea, butterflies in stomach					
Constipation & intermittent diarrhoea					
Trembling or twitching					
Muscle tightness or cramps					
Itching, dry skin, eczema or rashes					
Hot or cold flushes					
Pains in bones or joints					
Headaches or migraines					
Poor stamina, chronically tired					
Muscle weakness, jelly legs					
Repeated craving for sweet food or sugar					
Sleep problems, insomnia, nightmares, un-refreshing					
Totals					

STRESS TEST PART ONE:

Study the blocks of colours below then number them in order of preference, the colour you like the most (not for your clothing, colour of car or room decoration) but just which appeals to you the most as number 1, then your second facourite as 2 and so on till you give 8 to the colour you like the least.



Your ranking: 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐

Check your Stress, how stressed are you? This very simple test will take you no more than a couple of minutes. It uses the basic Luscher Colour Test and was developed by Dr Max Luscher almost 50 years ago. He based it on our primitive response to colours backed up by many hundreds of psychological profiles. Record your score from your ranking of each colour in the table below, Your total score will give your level of stress.

RANK	1	2	3	4	5	6	7	8
A	0	0	0	0	0	1	2	3
B	0	0	0	0	0	1	2	3
C	0	0	0	0	0	1	2	3
D	0	0	0	0	0	1	2	3
E	3	2	1	0	0	0	0	0
F	0	0	0	0	0	1	2	3
G	3	2	1	0	0	0	0	0
H	0	0	0	0	0	1	2	3
YOUR SCORE								

Your Grand Total ___

SEVERE STRESS	9 to11
HIGH STRESS	7 to 8
MODERATE STRESS	5 to 6
MILD STRESS	3 to 4
MINIMAL STRESS	0 to 2