

# Digital Breathing Assessment

Name:

DOB:

Patient ID/NHS number:

Physiotherapist Name:

Written/verbal consent to consultation via video:

Is the session recorded? **Y N**

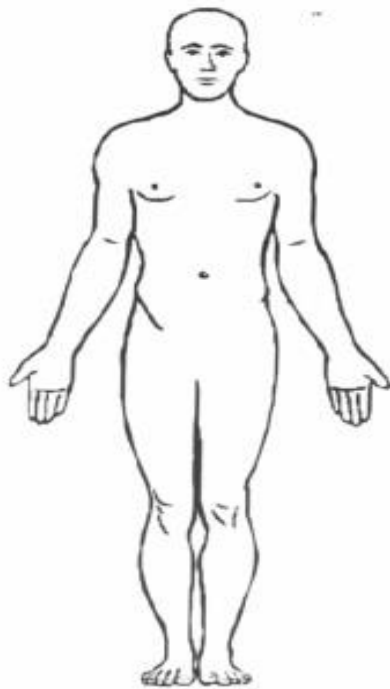
Date:

Time/units:

Page No.

## HPC

Symptoms:



Onset:

COVID:

Investigations:

Treatment so far:

Panic/Phobia:

Respiratory symptoms:

Nose

Throat/voice:

Cough:

Phlegm:

MSK issues:

Pelvic floor:

GORD:

Nijmegen Score:

SEBQ or Dyspnoea 12:

Fatigue score:

**Patients ID:**

*Date:*

*Page No.*

*Physiotherapist Name/signature:*

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**PMH – Physical/Psychological**

**DH**

Allergies:

**SH - Map of Lifestyle**

Daily routine:

Work:

Exercise:

Sleep:

Diet:

Hobbies:

Relaxation:

Family:

Smoke:

Recreational Drugs:

Alcohol:

**Lifestyle Triggers:**

**Observation:**

Body Posture/Tension:

Sighs/Yawns:

Speech:

**Patients ID:**

*Date:*

*Page No.*

*Physiotherapist Name/signature:*

*Units:*

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## **Objective Assessment of Breathing:**

### **Position of assessment:**

**Upper airway:** Nose:

Mouth:

### **Thoracic movement:**

Audible sound:

Breathing Rate:

Erratic/smooth:

I:E ratio:

Breath hold: (Exp > 30 sec /Insp > 30 sec )

**Analysis of Dysfunction:** Biomechanical/Biochemical/Psychological:

Further investigation of psychological state?

### **Treatment**

### **Plan**