

# Seasons of life... Physiotherapy and fitness for women

## Screening Form

Name:		Class start date:	
Address:		Home phone: Mobile phone:	
Post code:			
Age and DOB:		Occupation:	
Next of kin name:		Name of Physio/Health care provider:	
Next of kin phone:		Physio visit or other assessment:	YES NO
Discussed class with doctor/GP:	YES NO	Treatments eg: individual physio treatments... tummy exercises, or pelvic floor exercises?	
Name and Phone number of GP or specialist doctor:		Describe in more detail...	

	Yes	No		Yes	No
Do you have insulin dependant diabetes?			Do you have dizziness or fainting episodes?		
Do you have diet controlled diabetes?			Do you have arthritis?		
Do you have any respiratory problems?			Do you suffer from constipation?		
Do you have asthma?			Do you have continence / pelvic organ prolapse / pelvic floor issues?		
Do you smoke?			Have you recently had a baby?		
Do you have a chronic cough?			At what age did you experience menopause? (if applicable)		
Do you have shortness of breath?			Have you had any surgery?		
Do you have any heart problems?			If so please specify what and when:		
Do you suffer chest, neck, left jaw or left shoulder pain on exercise?			Have you had any major illnesses?		
Do you have high blood pressure?			If so please specify what and when:		
Have you had any brain injury or stroke?			Have you had any major injuries or needed treatment for back pain?		
Do you have swelling of ankles?			If so please specify what and when:		
Do you have epilepsy?			Do you have low bone density?		
Do you have kidney disease?			Do you have thyroid disease?		

	Yes	No		Yes	No
Do you exercise at present?			Do you have any other medical disorder?		
If so what activity, frequency and intensity:			If so please describe:		
Do you take any medication?					
If so please list name and state reasons for taking:					

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### *Client Responsibility Form*

To ensure your health and safety whilst participating in this exercise class take a moment to reflect on your screening form, and sign below to confirm your responsibilities.

I \_\_\_\_\_, understand that the physiotherapist requires full disclosure of my current and past health status to ensure a safe and effective exercise environment. I take responsibility for notifying her of my general health status and any other relevant issues.

I have told her all relevant information and will keep her informed of any changes to my health status.

Signed \_\_\_\_\_ Date \_\_ / \_\_ / \_\_

Physiotherapist Signature \_\_\_\_\_ Date \_\_ / \_\_ / \_\_

**Please ask your Doctor / Caregiver to sign below if you have any medical or physical disorders that may in any way affect your ability to exercise.**

I believe that the above mentioned woman has no health issues that would render it unsafe for her to exercise in a supervised Physiotherapeutic exercise class.

Name \_\_\_\_\_ Signed \_\_\_\_\_ Date \_\_ / \_\_ / \_\_