

Seasons of life... Physiotherapy and fitness for women

Post Natal Screening Form

Name:		Class start date:	
Address:		Home phone:	
Post code:		Work phone:	
Next of kin:		Mobile phone:	
Next of kin phone:		Occupation:	
Your DOB:		First baby:	YES NO
Baby DOB:		If not, state date of previous births:	
Name of doctor, midwife or obstetrician:			
Name of hospital or place of birth:		Have you required a Physio or other assessment:	YES NO
		If so, why?	

Physical health Questions	Yes	No	Health Questions	Yes	No
Low back pain?			Medications?		
Upper back pain?			If so, what?		
Neck or shoulder pain?					
Headaches?					
Other, eg: Carpal Tunnel Syndrome?			Heart disease?		
Describe:			Lung disease? / Asthma?		
			Kidney or Thyroid disease?		
Pelvic joint pain/ pelvic instability? If yes fill out pelvic instability form.			Epilepsy or seizures?		
Abdominal muscle separation?			Anaemia? / PPH?		
3 rd /4 th degree tear at birth (into anus)?			Diabetes?		
Continence/Pelvic Floor problems?			Other illnesses or major injuries?		
Describe:			Describe:		
Doing Pelvic Floor exercises?			Smoker?		
Are you currently exercising?			Any other health/pregnancy issues:		
Describe:			Describe:		
Previously exercising?			Other illnesses or major injuries?		
Describe:			Describe:		
Breast feeding?					
Birth or pregnancy history? E.g. Forceps, Caesarian birth or Hemorrhage etc.					
Describe:					

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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 __/__/__