

Seasons of life... Physiotherapy and fitness for women

Pregnancy 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 EDD/DOB:		If not, state date of previous births:	
Name of doctor, midwife or obstetrician:			
Name of hospital or intended place of birth:		Have you required a Physio or other assessment:	YES NO
		If so, why?	

Please contact me prior to attending first class if you tick YES to any of the questions in the right column

Physical health Questions	Yes	No	Health Specific Questions	Yes	No
Swimmer? (If Aqua class) Confident in water?			Any issues relevant to pool use?(Aqua Class only) Eg. Open wounds, infection etc.		
Low back pain?			If Pregnant, incompetent cervix?		
Upper back pain?			Risk of premature labour?		
Neck or shoulder pain?			Persistent bleeding? (2nd/3 rd trim)		
Headaches?			Placenta Praevia?		
Other, eg: round ligament pain?			Rupture of membranes?		
Describe:			Premature labour?		
Pelvic joint pain/ pelvic instability?			Preg induced high blood pressure? Pre eclampsia?		
Nausea or reflux?			Anaemia?		
Abdominal muscle separation?			Heart arrhythmias?		
Continence/Pelvic Floor problems?			Twin pregnancy?		
Doing pelvic floor exercises?			Intra Uterine Growth Retardation?		
Are you currently exercising?			Heart disease?		
Describe:			Lung disease?		
Previously exercising?			Epilepsy or seizures?		
Describe:			Diabetes?		
Breast feeding?			Thyroid disease?		
Any relevant past birth or past pregnancy history? Eg, Forceps/ Caesarian/Premature Labour etc.?			Smoker?		
			Any other health/pregnancy issues:		
Describe:			Describe:		

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Pre and Post Natal Pelvic Instability Screening Form

Pelvic Instability Specific Questions	Yes	No	Health Specific Questions	Yes	No
Pain at front of pelvis?			Other main aggravating factors or issues:		
Pain at back of pelvis, left?			Describe:		
Pain at back of pelvis, right?					
Back pain?					
Other, eg: round ligament pain?					
Describe:					
Pain on sitting?					
Pain on standing?					
Pain on walking?					
Pain with sit to stand?					
Pain with bed mobility?					

	No pain				Moderate pain					Max pain
Severity	1	2	3	4	5	6	7	8	9	10

Please indicate overall severity of pain.

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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. Please ask your caregiver every time you visit to confirm that it is still in your best interests to continue to exercise at Funky Mama Fitness.

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 __/__/__