PRE- SCREENING FOR POSTNATAL CLIENTS

NAME: BABY'S NAME DATE:

D.O.B: BABY'S DOB:

ADDRESS:

TEL NO:

OCCUPATION:

EMAIL: Receive our newsletter? YES / NO

PARTNER'S NAME:

ADDRESS (if different)

TEL (daytime)

DOCTOR: MIDWIFE:

TEL NO: NO. OF OTHER CHILDREN

Previous Exercise: (briefly outline)

Please tick if you have experienced any of the following, & adding past or present.

Shortness of breath	Heart Disease	Diabetes
Chest Pain	Hypoglycaemia	Multiple births
Miscarriage	Pelvic/abdominal cramps	High blood pressure
Eating Disorder	Vaginal bleeding	Knee problems
Vaginal Disorder	Arthritis	Back problems
Blood Disorder	Dizziness	Neck problems

Is there anything in your medical history you feel could affect your ability to exercise?

Are you taking any medication? Give details:

Is there anything about your pregnancy or birth you feel is relevant to the participation in an exercise programme?

What concerns you most about pregnancy, birth or the postnatal period?

What are your goals or reasons for participating in exercise?

FOR POSTNATAL ONLY

Type of delivery?

Did you have an episiotomy?

Are you breastfeeding?

How much sleep are you getting?

Do you have diastasis recti?

How does your pelvic floor feel?

Are you doing other exercise/what?

I can confirm that I have had the all clear by my GP to commence suitable postnatal exercise. I am aware that I must feel well prior to each class and will notify you (the trainer) should I feel unwell at any time during the class.

Whilst I am aware that every effort has been taken to ensure this exercise class is suitable for postnatal women. I understand that my participation and the safety of both my child/ren and myself are my responsibility. The supervision of my child/ren during a class is my responsibility, as I understand the Trainer is teaching in a class environment.

Signed:

Date: