Postnatal Health **ASSESSMENT**

THE pilatesroom ADELAIDE

OFFICE USE

Client name _____ Assessment date _____

Questionnaire

Title Mr/Mrs/Miss/other _____

First name _____

Family name _____

Address _____

_____

_____

Postal code _____

Home tel _____

Work tel _____

Mobile _____

Email _____

Date of birth _____ Age _____

Occupation _____

How did you find out about us? (e.g. friend, GP)

_____

Contact person and phone number in case of emergency _____

_____

Baby's name (s) _____

How old is your baby? _____ Birth date _____

Type of delivery? ☐ **Vaginal** ☐ **Caesarean Section**

Do you have any pre-existing medical conditions? ☐ YES ☐ NO If yes, please give details: _____

_____

Do you take any medication? ☐ YES ☐ NO If yes, please give details: _____

_____

Please answer questions with regards to THIS PREGNANCY. Please tick all that apply below:

YES	NO		YES	NO	
☐	☐	**a.** High blood pressure	☐	☐	**g.** Headaches
☐	☐	**b.** Pre-Eclampsia	☐	☐	**h.** Back pain
☐	☐	**c.** Gestational Diabetes	☐	☐	**i.** Pelvic pain
☐	☐	**d.** Bleeding	☐	☐	**j.** Incontinence
☐	☐	**e.** Pelvic instability	☐	☐	**k.** Shortness of breath
☐	☐	**f.** Tingling in hands	☐	☐	**l.** Rectus Diastasis (abdominal separation)

Please answer the following questions regarding PREVIOUS pregnancies. Please write N/A if not applicable:

How many previous pregnancies have you had? _____ How many babies / deliveries have you had? _____

Type of delivery? ☐ **Vaginal** No. _____ ☐ **Caesarean Section** No. _____

Please tick all that apply to any previous pregnancies: ☐ **Birth complications** ☐ **Grade 2+ tearing**

☐ **Rectus Diastasis (abdominal separation)** ☐ **Episiotomy** ☐ **Miscarriage**

Other relevant information: _____

_____

_____

Has your medical practitioner (GP or Obstetrician) provided you with written medical clearance to exercise?

☐ YES ☐ NO If yes, please attach.

RELEVANT PAST MEDICAL AND INJURY HISTORY
Where applicable please provide a brief explanation below

YES	NO	
☐	☐	**a.** Have you been involved in any major accidents? (e.g. car accident) Please detail below: _____
☐	☐	**b.** Have you had any major surgery? _____
☐	☐	**c.** Have you had any bone or stress fracture? If yes, do you currently have any metal plates/pins or screws in place? **YES** ☐ **NO** ☐ _____
☐	☐	**d.** Have you had any lower body (hip, knee, ankle, foot) problems/injuries? _____
☐	☐	**e.** Have you had any upper body (shoulder/elbow or wrist) problems/injuries? _____
☐	☐	**f.** Have you had any other muscle/ligament or tendon problems/injuries? _____
☐	☐	**g.** Have you had any neck problems/injuries? (e.g. whiplash) If so, please indicate date: _____
☐	☐	**h.** Have you had any low back problems/injuries? Please indicate the number of previous episodes: ☐ **0-5** ☐ **6-10** ☐ **11+** What was the most recent episode, date: _____
☐	☐	**i.** Have you been diagnosed as hypermobile (excessive joint mobility)? _____

OTHER INFORMATION

Is there any other condition or disability not covered above that your Physiotherapist should be aware of?

_____

_____

_____

Terms and conditions
The exercise programme we devise for you is based upon our sound teaching practice and the information you have provided above. You must therefore inform us about any change in your medical condition as soon as you become aware of it. If you experience any pain or dizziness during class you should stop what you are doing, inform us and consult your doctor. If you injure yourself in anyway during class you should inform us immediately. We accept no liability whatsoever for any injury or death unless the same is caused directly by negligence of one of our Physiotherapists. I declare that I have filled out this questionnaire truthfully, comprehensively and to the best of my ability I accept the above terms and conditions and agree to abide by them:

☐ Yes, I agree to the terms and conditions.

_____ _____

Signature *Date*