

POSTNATAL PILATES REGISTRATION FORM

Name: _____

Date of Birth: _____

Date of delivery: _____

Baby's name: _____

Length of Labour:

First Stage: _____ Second Stage: _____

Type of delivery:

Did you tear or require an episiotomy? _____

Any post delivery complications? _____

Is vaginal loss still occurring? _____

Medical Consultant: _____ Phone: _____

Have you had any problems with a past pregnancy or delivery? Yes No

Medical and Pregnancy Condition:

(Please tick if applicable)

Heart Disease

Kidney Disease

Thyroid Disease

Diabetes

High Blood Pressure

Epilepsy

Asthma

Other

Medical consultant's permission to attend postnatal exercises classes?

Yes No

Necessary Precautions: _____

Consultant's Signature: _____

PTO

Pelvic Floor

Are you having problems with stress or urge incontinence? O Yes O No

Abdominal Muscles

Is a diastasis recti present? How much? _____ O Yes O No

Joint Status

Do you have low back pain or sacroiliac joint pain? O Yes O No

Other joint or muscular problems? O Yes O No

Fitness History

Were you exercising during your pregnancy? o Yes o No

If so, what type of exercise? _____

Are you exercising at the moment? o Yes o No

If so, what type of exercise? _____

Have you discussed postnatal exercise classes with your medical consultant? O Yes O No

Is she/he in agreement with you joining these classes? O Yes O No

Please read the following carefully:

The postnatal exercise classes are led by fully qualified physiotherapists, and are designed specifically to suit the needs of postnatal women.

Instructors cannot assume responsibility for unforeseen circumstances.

It is important to discuss any problems, queries or doubts with your instructor prior to commencing the exercise classes. If you are not sure if it is appropriate for you to join the exercise class situation, your medical consultant’s opinion should be sought and he/she should complete the information below.

I have read the above and agree to inform the instructor should there be any changes to my condition, before participating in or continuing a class.

I have acknowledged that I have been strongly recommended to undertake an assessment screening prior to participating in the postnatal classes. My decision to decline this recommendation is my own responsibility.

Initial Assessment Undertaken

Signed: _____ **Date:** _____

Physiotherapist: _____ **Date:** _____

Modifications: _____

