VITALITY
Health & Rehab

Post-Natal Exercise Questionnaire

Name: ______________________________ DOB: ____________________
Phone: ____
Email: ____
Emergency Contact: ____

Baby's Name: ________________________ Baby's DOB: ______________
Type of Delivery (circle): VAGINAL CAESAREAN
Were there any complications during birth? **Y/N**
If yes, please provide additional information: ______________________
____
Date of your post-natal check-up: _________________________________

Please detail your past and present exercise activities:
Before pregnancy: ____
____
During pregnancy: ____
____
Post pregnancy: ____
____

Do you have a medical clearance (from GP or Obstetrician) to start exercise? **Y/N**
Are you breastfeeding? **Y/N**
Do you have any joint or pelvic pain? **Y/N**
Do you have any of the following medical conditions?

Asthma:	**Y/N**	Heart Conditions:	**Y/N**
Diabetes:	**Y/N**	Vertigo:	**Y/N**
Prolapse:	**Y/N**	High or Low Blood Pressure:	**Y/N**

If yes, please provide additional information:
____
____
____

Are you currently seeing any other service providers? **Y/N**
If yes, please provide additional information:

____
____

Do you give consent to share information with the service providers listed? **Y/N**

Are you currently experiencing any pain? **Y/N**
If yes, please provide additional information on the joints/muscles involved and rate your pain out of 10, with 1 being no pain and 10 being the worst pain.

____
____
____

1 2 3 4 5 6 7 8 9 10

What are some goals you would like to achieve from joining our Mums and Bubs class?

1. ____
2. ____
3. ____
4. ____

What level of intensity are you expecting during the Mums and Bubs class?

Light Intensity Moderate Intensity High Intensity Unsure

Do you have any concerns regarding your participation in the Mums and Bubs class?

____
____
____

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The following questions are in relation to your pelvic health. All information provided is confidential. Please tick the box that best describes your symptoms.

Do you experience urine leakage (incontinence) related to physical activity, such as coughing, sneezing, laughing, lifting or changing positions? **Y/N**
If yes, how much does it bother you?
Not at all Only a little bit Somewhat Moderately A lot

Do you experience frequent urination (needing to urinate more than usual, including during the night)? **Y/N**
If yes, how much does it bother you?
Not at all Only a little bit Somewhat Moderately A lot

Do you experience abnormal urgency to urinate? **Y/N**
If yes, how much does it bother you?
Not at all Only a little bit Somewhat Moderately A lot

Do you experience leakage associated with the feeling of urgency to urinate? **Y/N**
If yes, how much does it bother you?
Not at all Only a little bit Somewhat Moderately A lot

Do you experience the feeling of a bulge in the vagina (either the bladder, uterus, vagina or rectum? **Y/N**
If yes, how much does it bother you?
Not at all Only a little bit Somewhat Moderately A lot

Do you experience difficulty in emptying your bowels, such as straining? **Y/N**
If yes, how much does it bother you?
Not at all Only a little bit Somewhat Moderately A lot

Do you experience accidental leakage of faecal matter or gas? **Y/N**
If yes, how much does it bother you?
Not at all Only a little bit Somewhat Moderately A lot

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I ____ acknowledge that:

- All information provided is true and correct.
- This exercise program has been specifically designed for postnatal women.
- In normal circumstances the exercises should not harm me, or my baby in any way.
- I shall inform the Exercise Physiologist of any medical or pregnancy related changes prior to commencing exercise sessions.
- Vitality Health & Rehab will not be liable for any unforeseen circumstances or any circumstances of which I should have been aware but failed to notify them.
- I have read the above statement and agree to the terms and conditions laid out.

Date: _________________ Signature: ____