Pregnancy Baby and Me
Dietitian & Exercise Physiologist

Post-natal Exercise Screening

FunctionFit CLINICS

Name: D.O.B:	Reason for referral/visit:

Current health conditions/ diagnoses:

Medications:

Medication change in the last 3 months: _____

Family history of any of the following: (please tick)

☐ Type 2 Diabetes ☐ Heart disease ☐ Stroke ☐ Cancer ☐ High cholesterol ☐ High blood pressure

☐ Other _____

Smoking:	Non-Smoker ☐	Quit < 1 month ☐	Quit < ___ months	___ / day
Alcohol:	Non-Drinker ☐	Monthly, ___ / month	Weekly, ___ / week	___ / day
Stress levels ____/10 Stress impacts on my:	☐ Food habits	☐ Exercise habits	☐ Sleep quality/ quantity	
Sleep:	Hours/night: ____	Quality: _____	Previous sleep study: ☐ Yes (/ /20) ☐ No	

Pre-exercise Screening Questions

Instructions:

Patient to fill out section A

Patient to complete and review section B with appropriate healthcare team (GP or obstetrician). Healthcare team member signature is required if commencing exercise <6 weeks post-partum, or <12 weeks if birth outcome was a caesarean section, or if you tick ANY of the answers is question 8 of Section B.

A – General Health	YES	NO
1. Has your doctor ever said that you have a heart condition?		
If, YES please provide details _____	☐	☐
2. Do you feel pain in your chest when you do physical activity?	☐	☐
3. In the past month, have you had chest pain when you were not doing physical activity?	☐	☐
4. Do you lose your balance because of dizziness or do you ever lose consciousness?	☐	☐
5. Do you have back/pelvic or other joint problem that could be made worse by a change in your physical activity?	☐	☐
If, YES please provide details _____	☐	☐
6. Do you suffer from raised blood pressure?		
If YES, is/was this pregnancy related and how is it being treated? _____	☐	☐
7. Do you suffer from diabetes?		
If YES, is/was this pregnancy related and how is it being treated? _____	☐	☐
8. Do you suffer from asthma?		
If YES, how is this controlled? _____	☐	☐
9. Do you know of any other reason that could affect your participation in exercise?		
_____	☐	☐
SIGNED: _____ DATE: _____		
If you encounter any problems as you progress, please keep us informed		

B - Pre-exercise health checklist		
Post-natal health	YES	NO

1. Date of delivery: _____ Today's Date: _____ ☐ ☐
2. Have you had your postnatal check? ☐ ☐

   If yes, please provide details: _____

   If no, please advise of the scheduled date _____
3. Has post-partum bleeding ceased since the birth of your baby?
4. Type of delivery you had:

   ☐ Vaginal ☐ Forceps ☐ Ventouse ☐ Caesarean Section

   Details of birth experience (duration, pushing stage, recovery, support – will be discussed further with practitioner):

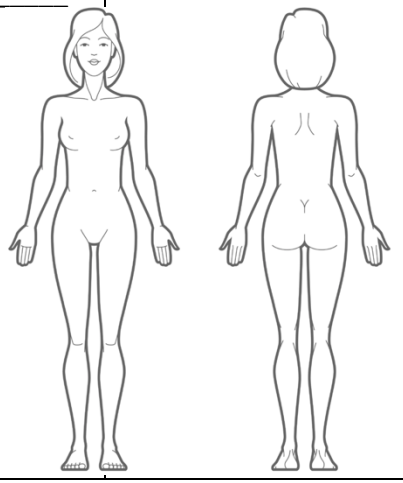
   _____

   _____
5. Are you: ☐ ☐

   ☐ breastfeeding ☐ bottle feeding ☐ both
6. Do you have any existing or new injuries or joint problems? If yes, please provide details:

   _____

   _____
7. Have you been previously/ currently experiencing pain/ issues in any of the following areas (check boxes or mark picture):



☐ Carpal Tunnel/Wrist Pain? ☐ Neck / shoulder pain ☐ Mid back

☐ lower back (lumbar- gluteal region) ☐ Symphysis Pubis Pain? ☐ Shoulders/Ankles/Feet?

☐ Diastasis Recti – Separation of Tummy Muscles ☐ Tail bone (coccyx) ☐ Hip pain

☐ Knee Pain (front or side)? ☐ Pelvic nerve damage during birthing

If you marked any of the above feel free to provide further details:

_____

_____

8. Have you been advised of any complications with/ are experiencing complications with any of the following?

- ☐ Thrombosis, DVT, Blood Clots
- ☐ Breast Health/Breast Feeding Issues?
- ☐ Lack of bladder or bowel Control?
- ☐ Any heaviness/ dragging in the vagina/ rectum or pain with intercourse?
- ☐ C-Section wound/scar discomfort or slow healing
- ☐ Any unexplained bleeding
- ☐ None of the above

To be completed by doctor/ physician:

Recommended/approved: ☐ Contraindicated until further investigations completed ☐

Details of physical activity recommendation: _____

Declaration

I, _____ (patient's name), have discussed my plans to participate in physical activity after pregnancy with my health care provider and I have obtained his/her approval to begin participation.

Signed: _____ (patient's signature)

Name of Healthcare provider: _____

Signature of Healthcare provider: _____ Date: _____ (of both signatures above)

To be completed by Ante/Post Natal Practitioner only:

Date received: _____

Notes:

INFORMED CONSENT FOR PARTICIPATION IN AN EXERCISE TRAINING PROGRAM
FOR CURRENT AND/OR ANY FUTURE RELATED SERVICES WITH FUNCTIONFIT CLINICS

Please read the following information and tick the box if you have read and understand the statement.

☐ Explanation of tests: You may perform a number of tests/ assessments specific to your injury/condition. Regarding exercise, this may include efforts such as bending forward, pulling, lifting, walking and stair climbing. The assessment will stop if you show signs of intolerance. Regarding diet, this may involve a reflective questioning of dietary patterns. You are free to terminate the assessment at any time.

☐ Benefits to be expected: The results of the assessment will be used to determine your suitability to undertake active treatment or dietary changes to help decide on the best type of treatment.

☐ Freedom of consent: Your permission to perform this assessment is voluntary. You are free to stop the test/ assessment at any point if you so desire.

☐ Inquiries: Any questions about the methods used in the assessment or the results of your test are encouraged. If you have any concerns or problems, please ask your practitioner for further explanations.

☐ Acknowledgment: I acknowledge that I am responsible for discussing the rare risks associated with my proposed care which may include, although not limited to muscle and joint soreness, sprains and strains, nausea and dizziness, fractures, disc injuries, strokes, heart attack, hypoglycaemic episodes (or like episodes) and/or an exacerbation and/or aggravation of my underlying conditions. I acknowledge that I will ask questions about the nature, extent and purpose of the proposed care and I remain responsible for making a decision to consent for the care to proceed. I acknowledge that I am aware of and understand the potential risks, and that results are not guaranteed. I do not expect the practitioner to be able to anticipate all potential risks and complications associated with the proposed care.

☐ Informed Consent: I have read this form and have had the assessment procedures explained to me. I have had the opportunity to ask questions that have been answered to my satisfaction. I consent to participate in the assessment. I also give permission for Functionfit Clinics to disclose details of my pre-assessment medical screen questionnaire and the results of the assessment and my treatment with the treating parties.

Name:

_____

Patient's Signature: **Date:**

(Parent or Guardian to sign if patient is under 18 years)

_____ _____

Privacy Disclaimer: ***We take every precaution to keep email and fax correspondence secure and confidential. However, with any system there is always a small risk that e-mail and fax communication can be intercepted in transmission or misdirected.***

I have read and understand the privacy disclaimer and I consent to correspondence with the Functionfit Clinics clinicians and reception by email/fax, including the exchange of sensitive health/medical information.

Signature: _____ Date: _____