

POSTPARTUM PHYSICAL ACTIVITY READINESS QUESTIONNAIRE

CONTACT INFORMATION & ABOUT YOU

Your Name:

Your baby's name (if they will be attending):

Phone Number:

Email Address:

Would you like Anne-Marie Mougeot contact you regarding class or workshop offerings and occasional newsletters?

Yes

No

Age:

Date of birth:

Gender:

Pronouns:

How did you hear about this class?

Please fill out the following intake form. The information gathered here will be kept confidential and will be used in order to offer appropriate guidance throughout the Postnatal Exercise Classes. If you are not comfortable talking any of the following issues with me, you may leave the box blank. (Please note you may change your decision at any time). As you go through the rest of this form, feel free to leave the questions that you do not feel comfortable answering blank.

YOUR BIRTH EXPERIENCE(S)

Date(s) of birth(s):

Number of pregnancies:

Birth type (vaginal/assisted/c-section):

Tearing (degree if known):

Postnatal bleeding status:

Other complications if any:

Have you had your six-week check with your GP or Midwife?

If yes, date of appointment:

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Did your GP or Midwife clear you for exercise?

Did your GP or Midwife recommend any limitations for your exercise?

If yes, what were they?

Breastfeeding status:

Postpartum bleeding status:

Current activity level:

Have you met with any of the following health care professionals during or after your pregnancy? *(please indicate whether current or previous).*

...Physiotherapist

...*Pelvic Health Physiotherapist

...Acupuncturist

..Massage Therapist

...Chiropractor

..Osteopathic Practitioner

...Other (please specify):

**If you have worked with a Pelvic Health Physiotherapist, have they recommended any limitations to exercise? Please describe. (If you would like me to discuss these limitations with your pelvic health physio, please let me know.)*

Please describe reasons for your visit(s):

Do/have you experienced any of the following symptoms? If so, please provide relevant details (start date, any treatment(s), current status) etc....

MUSCULOSKELETAL

...Pain in the central pubic area

...Lower back pain or sciatica – location:

...Neck pain

...Coccyx (tailbone) damage or pain

...Knee pain

...Any other joint pain (e.g., wrist) – please specify:

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WOMEN'S HEALTH

- ...Heaviness, dragging, or bulging in the pelvic area
- ...Diagnosis of pelvic organ prolapse (uterus/bladder/rectum/vaginal)
- ...Diagnosis of diastasis recti
- ...Hysterectomy
- ...Leaking urine when you cough/sneeze/exercise
- ...Strong and sudden urge to urinate
- ...Leaking of urine
- ...Difficulty or discomfort with passing urine
- ...Uncontrollable gas
- ...Leaking of feces
- ...Straining during bowel movements (constipation)
- ...Pain in the perineum during sexual intercourse (or any other time)
- ...Unexplained bleeding during or after exercise

OTHER

- ...Hemorrhoids
- ...Constipation
- ...High blood pressure
- ...Varicose veins
- ...Gestational diabetes
- ...Low blood pressure

LIFESTYLE

The purpose of the following questions is to help me, as your Postnatal Exercise Class Instructor, to get a better understanding of your lifestyle.

How much sleep do you get in a 24-hour period?

Please rate your general stress level on a scale of 1–10 (1=little, 10=extreme):

Do you feel depressed or anxious, or do you suffer from mood swings?

Have you accessed or utilized any treatments for your mental health support?

Is there anything else that you would like to share with me?

Thank you for taking the time to share your information with me. **Once you have completed this form, please email it to anne-marie@islandoptimal.com** or bring it to your first postnatal exercise class. If you have any questions regarding your participation in this class, please do not hesitate to contact me at the email address above.