Pre-Exercise Screening

Postpartum

General

Full Name:

Health Care Professional:

Address:

Weeks / Months Postpartum:

Phone:

Baby birth date: / /

Birthdate: / /

General Health

Do you have a heart condition or ever suffered from a stroke?	Yes / No
Do you ever experience unexplained pains in your chest at rest or during physical activity?	Yes / No
Do you ever feel faint / dizzy or lose balance in exercise?	Yes / No
Have you had an asthma attack in the past 12 months?	Yes / No
If you have diabetes have you had trouble controlling your blood sugar in the past 3 months?	Yes / No
Do you have any diagnosed muscle or joint problems that could be made worse from physical activity?	Yes / No
Do you have any other condition that may require special consideration for you to exercise?	Yes / No

*If you answered yes to any of the above you should seek guidance from a health care professional before participating in any further physical activity.

Returning to Exercise Postpartum

Factors to be considered when returning to exercise postpartum include:

- Length of time since the birth (> 6 weeks postpartum)
- The pregnancy
- The birth mode, length and intensity
- Any injuries from pregnancy or birth
- How the first few weeks / months postpartum have been
- How much support is available postpartum from friends, family and professionals

Are you currently **less than** six weeks postpartum?	Yes / No
Do you have vaginal heaviness?	Yes / No
Do you have pelvic organ prolapse?	Yes / No / Unsure
Do you have any incontinence?	Yes / No
Do you have any abdominal separation / diastasis recti of the abdominal muscles (DRAM)?	Yes / No / Unsure
Did you have an episiotomy? If so, is it healing well?	Yes / No _____
Did you have any tears in labour? If so, was it a 2nd degree, 3a, 3b, 3c or 4th degree? If so, is it healing well?	Yes / No _____
Did you have a c-section? If so, how is the wound feeling?	Yes / No _____ _____

*If you answered yes to any of the above you should discuss options to modify your physical activity with a healthcare professional before continuing with any further physical activity.

History

Was this your first baby born? If no, how many other children do you have?	Yes / No _____
What mode of delivery did you have?	o C-Section o Vaginal o Assisted
Since your baby was born, what type of exercise have you been doing? (tick all that apply)	o None o Walking o Pelvic floor exercises o Gentle core exercises o Other _____
Have you been performing pelvic floor exercises daily?	Yes / No
Were you active in your pregnancy?	Yes / No
Were you active pre-pregnancy?	Yes / No

Other Comments

Do you have any other comments or questions you would like to discuss before starting your training?

_____

_____

_____

_____

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

Signed: _____ (signature) Date: _____