

HEALTH CLEARANCE FORM

Your health is our business. This information will help us deliver the safest and best environment for you to exercise. Information will be kept confidential. Please complete the following and **bring the form to your first session:**

Name	Date of Birth	Age
Telephone	H	M
Emergency Contact Name	GP/Specialist/Midwife	
		Phone Number

PREGNANCY & MEDICAL HISTORY

It is important for us to know about your pregnancy and birth of your children as this helps us to identify your specific needs.

How many pregnancies have you had?	How many children do you have now?
If you are pregnant when is your baby due? / / How many weeks are you currently?	

If you have answer YES to any of the following pregnancy complications or health conditions it may be unsafe to exercise. If you answer YES to any of the following please obtain a written clearance to exercise from your Medical Practitioner together with any safety precautions we need to follow during exercise.

Pregnancy Contraindications	Yes	No	Further Information
Pregnant History of 3+ miscarriages			
Vaginal Bleeding			
Cervical weakness / stitch			
Placenta Praevia			
Ruptured Membranes			
History of Pre term labour			
Baby not growing			
General Contraindications			
Toxaemia / pre-eclampsia			
Poorly controlled thyroid			
General Blood clots			
Heart / Lung Condition			
Asthma			
High/Low blood pressure			
Diabetes(uncontrolled)			
Epilepsy			
Anaemia			

Do you have any of the following medical conditions that may require your exercise to be modified?

General Precautions	Yes	No	Further Information
Low back Pain			
Pelvic joint problems			
a. Sacroiliac			
b. Pubic symphysis			
Dizziness			
Split Abdominal muscles			
Varicose Veins			
Very low fitness level			
Any other problems?			
Are you a swimmer?			Please circle this if it is true I do not feel confident putting my head under water
Medications?			

CHILDBIRTH HISTORY (Fill this in if you have just had a baby or if you have other children)

When was your last child born?	Age	Birth Weight
Describe your child's health		
Circle which statements apply to you: Caesarian. Why? Vaginal Birth Forceps Vacuume		
I pushed for more than 1.5 hours. Episiotomy 3 rd or 4 th degree tear A graze I am breast feeding		
Please describe the birth of any other children (if any):		

It is important for us to know about how your pelvic floor muscles are functioning so that we can help you to address and prevent any problems. **If you answer YES to any of these questions we strongly recommend a 1:1 appointment with the physiotherapist at Innerstrength.**

Are you currently experiencing incontinence of urine, wind or faeces?	YES	NO
Do you have trouble feeling your pelvic floor lift or let go?	YES	NO
Do you have trouble stopping the flow of wee on the toilet?	YES	NO
Do you have a prolapse, feel a vaginal lump, heaviness or dragging?	YES	NO
Is sexual activity causing you significant discomfort?	YES	NO
Are you struggling with Constipation?	YES	NO

Do you normally exercise?	What exercise do you normally do?
What exercise do you want to get back to?	



ACKNOWLEDGEMENT AND CONSENT:

Our exercise classes are designed for safe exercise. Under normal circumstances, none of the exercises in the program should cause any danger to you. The physiotherapist cannot assume responsibility for any unforeseen circumstances. If your medical condition changes from that described above, you must notify the physiotherapist before your class.

I have read the above and the document "IMPORTANT FOR YOU TO READ" accessible online and agree to abide with this and to inform the physiotherapist should there be any changes to my medical condition, before participating in these exercise classes.

Recommended individual physiotherapy treatment: Yes NO Date: _____

Signature: _____ Date: _____

Physiotherapist: _____ Date: _____

Your Modifications: _____

Additional Issues / Modifications / Notes

Recommended individual physiotherapy treatment; Date: _____ Date: _____ Date: _____

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