

Preggy Fitness

PATIENT INFORMATION FORM

Please print and complete this form prior to your first pregy class and then either e-mail to info@rowvillephysio.com.au, drop off at clinic reception, or bring with you to your first class.

NAME: _____

CONTACT PHONE NO: _____

AGE: _____

DOCTOR: _____ **DR PHONE NO:** _____

EMERGENCY CONTACT: _____

Current week of gestation: _____

Is this your first pregnancy? **YES** **NO**
If no, how many pregnancies have you had? _____

Do you participate in regular exercise? **YES** **NO**
If so, what do you do? _____

MEDICAL HISTORY: Please tick if you have any of the following:

- Pregnancy-induced high blood pressure (pre-eclampsia)
- Low Blood Pressure
- Premature rupture of membranes
- Incompetent cervix
- Persistent second - or third - trimester bleeding
- Placenta praevia
- Poor foetal growth
- Heart or Lung condition. Please describe _____
- Incontinence
- Prolapse
- Diabetes
- Joint or muscular problems. Please describe _____
- Low back or pelvic pain

The exercises are designed to be safe for pregnancy and in the post natal period. Under normal circumstances, the exercises should not cause you any harm. The physiotherapist cannot assume any responsibility for any unforeseen circumstances. If your health changes from that described here, or if you notice any adverse reaction during the exercise class, you must notify the physiotherapist before continuing the classes.

I have read the above and I acknowledge that my GP/obstetrician has declared me suitable to participate in the Preggy Fitness class. I will inform the physiotherapist before participating in the class should there be any change to my health.

Signed: _____ Date: _____