



# HEALTH SCREENING QUESTIONNAIRE

All information contained in this questionnaire is strictly confidential

**CLIENT INFORMATION**

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Mobile number: \_\_\_\_\_

Email: \_\_\_\_\_

GP name and address: \_\_\_\_\_

Occupation: \_\_\_\_\_

Current weeks pregnant: \_\_\_\_\_ Estimated Date of Delivery: \_\_\_\_\_

Emergency Contact (Name & Number): \_\_\_\_\_

**GENERAL INFORMATION** (please tick the answer that applies to you)

Is this your first pregnancy? Yes/No

Have you suffered miscarriage in any previous pregnancies, vaginal bleeding or other complications? Yes/No

If Yes, please provide details: \_\_\_\_\_

How many children do you have? \_\_\_\_\_

If there is anything about your previous birth experience that you would like us to be aware of, please elaborate here: \_\_\_\_\_

Are you having any medical treatment for complications in your pregnancy? Yes/No

If Yes, please provide details: \_\_\_\_\_

Please list any past medical problems diagnosed \_\_\_\_\_

**Do you currently have any of the following:**

Serious heart, respiratory, renal or thyroid disease?	Yes/No
Type 1 or Type 2 Diabetes?	Yes/No
Asthma?	Yes/No
Anaemia?	Yes/No
Epilepsy?	Yes/No
Swelling in hands, ankles or face?	Yes/No
High or Low Blood Pressure?	Yes/No
Urinary tract, bladder or kidney infection in the last year?	Yes/No
Do you suffer with any problems in controlling urination?	Yes/No
Do you suffer from any back, neck or knee problems?	Yes/No
Pregnancy Related Pelvic Girdle Pain or Symphysis Pubis Dysfunction?	Yes/No
Are you on any medication?	Yes/No

If Yes to any of the questions, please provide details: \_\_\_\_\_

**GENERAL INFORMATION** (continued)

Previous Exercise (briefly outline) \_\_\_\_\_

Have you been exercising during this pregnancy? Yes/No

Please provide details: \_\_\_\_\_

What concerns you most (if any) about pregnancy, birth or the postnatal period? \_\_\_\_\_

## THE BUMP ROOM PARTICIPATION INFORMED CONSENT

You must agree to the client disclaimer below before participating in our classes.

### PLEASE READ CAREFULLY, SIGN AND DATE AT THE BOTTOM:

Every precaution will be taken to ensure your safety during participation in these classes. With that in mind, you are aware of the risks involved. You agree that certain elements of the classes will be physically demanding. You agree that you are physically capable of participating in the sessions and accept full and complete responsibility for your own participation in the class. You agree that should any medical or physical problem arise prior to or during a class which is likely to affect your ability to participate in a class you will inform the Physiotherapist Instructor and discuss.

I agree to the terms and conditions stated above.

My GP and/or Obstetrician are aware that I am commencing exercise and have given me clearance to attend.

The Bump Room classes will begin at a low level and will be advanced in stages. You may stop whenever you wish because of feelings of fatigue or discomfort.

Please be aware of the following warning signs to stop exercising when pregnant;

**VAGINAL BLEEDING, SHORTNESS OF BREATH AT REST, DIZZINESS, HEADACHE, CHANGES IN VISION, CHEST PAIN, SEVERE ABDOMINAL OR BACK PAIN, CALF PAIN OR SWELLING, AMNIOTIC FLUID LEAKAGE.**

Please tick if you consent to be added to your local Bump Room 'Whats App' group managed by your instructor to share information between the group members.

Please tick here to confirm that we can contact you about research.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

“Listen To Your Body” and talk to your Physiotherapist Instructor