Ante- and Postnatal Client Enrolment Form

BODY CONTROL PILATES®

ALL INFORMATION WILL BE TREATED IN THE STRICTEST OF CONFIDENCE

PERSONAL DETAILS:

NAME:

ADDRESS:

CONTACT TELEPHONE NO:

MOBILE NO:

EMAIL ADDRESS:

OCCUPATION:

DATE OF BIRTH:

EMERGENCY CONTACT DETAILS:

If possible, please give details of two people whom we may contact in case of emergency.

EMERGENCY CONTACT NAME:

EMERGENCY CONTACT NO:

EMERGENCY CONTACT NAME:

EMERGENCY CONTACT NO:

DOCTOR'S NAME:

DOCTOR'S TELEPHONE NO:

DO YOU GIVE PERMISSION FOR US TO CONTACT YOUR DOCTOR/MEDICAL PRACTITIONER?

☐ YES ☐ NO

YOUR BACKGROUND AND YOUR HEALTH:

Questions 1-9 relate to antenatal clients only and to your current pregnancy. (Postnatal clients please go to question 10 to resume questionnaire).

1. NAME OF MIDWIFE/DOULA:

2. MIDWIFE/DOULA'S TELEPHONE NO:

3. HOSPITAL/ANTENATAL CLINIC/BIRTH CENTRE:

4. DUE DATE OF YOUR CURRENT PREGNANCY:

5. PLEASE TICK WHICH TRIMESTER YOU ARE CURRENTLY IN.

- ☐ First Trimester 0-12 weeks
- ☐ Second Trimester 13–26 weeks
- ☐ Third Trimester 27–40 weeks

6. DID YOU CONCEIVE NATURALLY OR BY IVF? IF VIA IVF, HOW MANY TREATMENTS DID YOU HAVE?

7. DO YOU HAVE ANY PARTICULAR WORRIES OR CONCERNS ABOUT EXERCISE DURING PREGNANCY?

8. HAVE YOU CHOSEN A PARTICULAR BIRTHING PLAN? IF SO, PLEASE GIVE BRIEF DETAILS BELOW:

9. HAS YOUR DOCTOR OR MIDWIFE GIVEN YOU MEDICAL CLEARANCE TO TAKE PART IN EXERCISE?

☐ YES ☐ NO

Client's signature.....

ANTE- AND POSTNATAL QUESTIONS::

The following questions (10–25) relate to both ante- and postnatal clients.

10. IF YOU HAVE HAD CHILDREN, PLEASE WOULD YOU GIVE THEIR DATES OF BIRTH BELOW:

11. PLEASE TICK THE METHODS OF DELIVERY FOR THESE CHILDREN:

- ☐ Vaginal delivery (no medical intervention)
- ☐ Vaginal delivery with medical intervention (e.g. forceps)
- ☐ Caesarean section

12. DID YOU HAVE ANY PROBLEMS DURING YOUR PREVIOUS PREGNANCIES, BIRTHS OR IN THE POSTNATAL PERIOD THAT MAY IMPACT YOUR ABILITY TO EXERCISE?

13. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING, PAST OR PRESENT?

- ☐ Miscarriage
- ☐ Incompetent cervix
- ☐ Pre eclampsia
- ☐ Chest pains
- ☐ Seizures
- ☐ Heart disease
- ☐ Pelvic/abdominal cramps
- ☐ Vaginal bleeding
- ☐ Multiple gestation (twins etc.)
- ☐ Shortness of breath
- ☐ Eating disorder
- ☐ Blood disorder
- ☐ Hypoglycaemia
- ☐ Diabetes

14. HAVE YOU EVER SUFFERED WITH PELVIC GIRDLE PAIN? E.G. SYMPHYSIS PUBIS DYSFUNCTION, SACROILIAC JOINT PAIN

☐ YES ☐ NO

If Yes, please give brief details below of condition and treatment (e.g. physiotherapy)

15. DO YOU LOSE YOUR BALANCE BECAUSE OF DIZZINESS OR DO YOU EVER LOSE CONSCIOUSNESS, FEEL FAINT OR DIZZY?

☐ YES ☐ NO

16. IS YOUR BLOOD PRESSURE?

☐ Normal ☐ Low ☐ High

If High, is it being medically controlled?

☐ YES ☐ NO

17. HAVE YOU HAD MAJOR SURGERY IN THE LAST 10 YEARS? (EXCEPT CAESAREAN SECTION)

☐ YES ☐ NO

If Yes, please give details:

18. HAVE YOU HAD MINOR SURGERY IN THE LAST TWO YEARS?

☐ YES ☐ NO

If Yes, please give details:

19. HAVE YOU EVER BEEN TOLD THAT YOU HAVE ARTHRITIC JOINTS, OSTEOPOROSIS OR ANY BONE OR JOINT PROBLEM THAT MAY AFFECT YOUR ABILITY TO EXERCISE?

☐ YES ☐ NO

If Yes, please give details:

20. DO YOU HAVE NECK OR BACK PAIN?

☐ YES ☐ NO

If Yes, please give details:

21. DO YOU HAVE PAIN OR RESTRICTED MOVEMENT IN ANY OTHER JOINTS? (E.G. HIP, KNEE, ANKLE, SHOULDER)?

☐ YES ☐ NO

If Yes, please give details:

22. HAVE YOU BEEN DIAGNOSED AS HAVING HYPERMOBILE JOINTS? (EXCESSIVE JOINT MOVEMENT)

☐ YES ☐ NO

23. ARE THERE ANY MOVEMENTS OR POSITIONS WHICH CAUSE YOU PAIN?

☐ YES ☐ NO

If Yes, please give details:

24. IS THERE ANYTHING ELSE IN YOUR MEDICAL HISTORY THAT YOU FEEL COULD AFFECT YOUR ABILITY TO EXERCISE?

☐ YES ☐ NO

If Yes, please give details:

25. ARE YOU TAKING ANY MEDICATIONS THAT MAY AFFECT YOUR ABILITY TO EXERCISE?

☐ YES ☐ NO

If Yes, please give details:

POSTNATAL CLIENTS ONLY

The following questions (26-33) relate to postnatal clients only. Antenatal clients please go to question 34.

26. HOW MANY WEEKS POSTNATAL ARE YOU?

27. DID YOU HAVE A LENGTHY OR DIFFICULT LABOUR?

☐ YES ☐ NO

28. METHOD OF DELIVERY OF YOUR RECENT BABY: (PLEASE TICK)

☐ Caesarean section
☐ Vaginal delivery (no medical intervention)
☐ Vaginal delivery with medical intervention (e.g. forceps)

29. IF YOU HAD A VAGINAL DELIVERY, DID YOU HAVE STITCHES TO REPAIR AN EPISIOTOMY OR TEAR?

☐ YES ☐ NO

If Yes, have you healed?

☐ YES ☐ NO

30. DO YOU HAVE ANY PARTICULAR CONCERNS OR WORRIES ABOUT YOUR PELVIC FLOOR HEALTH, E.G. ARE YOU EXPERIENCING URINE LEAKAGE? HAVE YOU NOTICED ANYTHING UNUSUAL OR HAD A LACK OF SENSATION?

31. ARE YOU BREASTFEEDING?

☐ YES ☐ NO

32. DO YOU HAVE ANY PARTICULAR CONCERNS OR WORRIES ABOUT EXERCISE IN THE POSTNATAL PERIOD?

☐ YES ☐ NO

If Yes, please give details:

33. HAS YOUR DOCTOR, CONSULTANT OR MIDWIFE GIVEN YOU MEDICAL CLEARANCE TO TAKE PART IN EXERCISE ?

☐ YES ☐ NO

Client's signature.....

EXERCISE HISTORY

The following questions (34-39) are for both ante- and postnatal clients.

34. DO YOU TAKE REGULAR EXERCISE?

☐ YES ☐ NO

If Yes, please tick and indicate the number of sessions per week:

Cardiovascular activities:
Gym workouts:
Yoga:
Other:

35. WILL THIS BE THE FIRST TIME THAT YOU HAVE PRACTISED PILATES?

☐ YES ☐ NO

If No, have you previously attended (please tick)

☐ Studio
☐ Body Control Pilates matwork classes
☐ Other Pilates matwork
☐ At home: books, DVDS

Number of classes attended:
☐ 0-5 ☐ 5-10 ☐ 10-20 ☐ 20+

YOUR AIMS

For both ante- and postnatal clients.

36. WHAT ARE YOUR REASONS FOR TAKING UP PILATES AT THIS TIME?

37. DO YOU HAVE ANY PARTICULAR GOALS THAT YOU WISH TO ACHIEVE OVER THE NEXT 3 MONTHS?

38. WHAT LONGER TERM HEALTH BENEFITS OR GOALS WOULD YOU LIKE TO ACHIEVE OVER THE NEXT 12 MONTHS?

39. ARE THERE ANY FACTORS THAT YOUR TEACHER SHOULD BE AWARE OF THAT MAY PREVENT YOU FROM REGULARLY ATTENDING CLASSES? (SUCH AS CHILD CARE, LACK OF TRANSPORT, WORK OR FAMILY COMMITMENTS).

IMPORTANT INFORMATION

Please advise us before commencing any session if, for any reason, your health or ability to exercise changes.

If you are pregnant, we strongly recommend that you check with your doctor/midwife at regular intervals (perhaps at your antenatal check ups) if it is still ok for you to exercise.

If you are in doubt about the suitability of the exercises, please refer back to your medical practitioner. The teacher can accept no liability for personal injury related to participation in a session if:

- Your doctor has not given you medical clearance to exercise/to continue to exercise
- You fail to observe instructions on safety and technique
- Such injury is caused by the negligence of another participant in the class/studio

The exercises, and the transitions between exercises, should be performed at a pace which feels comfortable for you.

Please tell the teacher if you feel any discomfort, dizziness, nausea or pain during the session.

Please also inform the teacher if you felt discomfort or pain after a previous session.

I understand that Pilates exercises involve hands-on correction and I hereby consent for my teachers to work in this way.

I confirm that I have read and understood the advice on the left and the information I have given is correct.

I confirm that my teacher may use the contents of this form, and any other information I may later provide, for teaching purposes, and that this information:

- will be used in confidence and stored securely
- will not, in any circumstances, be shared with a third party without my written consent, unless that party is another (Body Control) Pilates teacher who will teach me.
- may be retained by the teacher for a period of time such as complies with professional, legal and insurance requirements that they must fulfil

I confirm agreement for my teacher to contact me with information on classes and other Pilates-related activities, and understand that I have the right to withdraw this 'consent to be contacted' at any time.

Signed:

Client..... Date.....

Teacher..... Date.....