Registration Form

Date: ___/___/_____ Name: _________________________________

DOB: ___/___/_____ Address: _________________________________

Occupation: _______________________________ _________________________________

Phone: ___________________(m) _____________________(h) Email: _________________________________

Obstetrician: _______________________________________ Tel:_______________________________________

Emergency contact: _________________________________ Tel: _______________________________________

Pregnancy & Post Natal Information

Due date/Birth date:________________________ Hospital:___________________________________

Is this your first pregnancy/delivery? ☐ Yes ☐ No Age of Children?:______________

Please give relevant details or problems from previous AND/OR current pregnancy/delivery:

____

Medical Information (please tick)

☐ High blood pressure
☐ Dizzziness/fainting
☐ Vaginal bleeding
☐ Dizziness/Faintness
☐ Diabetes
☐ Heart Disease
☐ Thyroid disease
☐ Kidney Disease
☐ Placenta Previa
☐ Multiple Pregnancy
☐ Cervical Stitch
☐ Reduced foetal mvt
☐ Pre eclampsia
☐ Asthma
☐ Swelling hands/feet

Discomforts (pease tick)

☐ Pelvic joint pain
☐ Back pain
☐ Muscular pain
☐ Altered bladder control
☐ Reflux/heart burn
☐ Wrist pain

Other:____

If you ticked **"YES"** to any of the above please provide details:

____

Please list current medication: ____

Exercise History

What exercise have you been doing prior to pregnancy/delivery?

____

What and how often are you exercising now?

____

Have you received clearance from your obstetrician to exercise? ☐ Yes ☐ No

Acknowledgement & Release

I the undersigned acknowledge that:

- *This exercise program has been specifically designed by a physiotherapist for pre- post natal women and in normal circumstances the exercises should not harm me or my baby in any way.*
- *I shall inform my instructor of any medical or pregnancy related changes prior to commencing the class.*
- *Bumps Pilates will not be liable in any way for any unforeseen circumstances, should I have been aware and failed to inform them.*
- *I give permission for Bumps Pilates to contact my emergency contact numbers as listed if the need arise.*
- *I have read the above statement and agree to be bound by it and to release Bumps Pilates from all claims*.

Signature:____ **Date:**______________

If you answered **Yes to any of the above **medical conditions** it is important and recommended that you **gain approval** from your **medical practitioner to participate in the pre-post natal pilates classes**.

Signature:____(medical practitioner) Date: ______________

Precautions:____