BB Client Health History & Core Screening

PLEASE NOTE THIS DOCUMENT HAS 2 PAGES

Name: _____ Phone: _____

Mother's age: _____ Gestational age/baby's age: _____

Emergency contact: _____ Phone: _____

Does your physician know you are participating in this exercise program? _____

Are you taking any medications? If so, please list medication, dose & reason.

_____

BACK PAIN HISTORY

Do you have any back or pelvic pain now? Y / N

Have you had any back or pelvic pain in past pregnancies or recently? Y / N

ABDOMINAL RECOVERY

DRA MEASUREMENT (if known): _____

Do you do any other abdominal exercises such as sit ups or crunches? Y / N

Have you noticed a bulge or dome appearance between your stomach muscles

when you get up off the floor/out of bed/ off a chair? Y / N

Do you experience any pain or pressure in your abdomen or pubic area? Y / N

Do you have any residual pain or swelling due to cesarean birth? Y / N

PELVIC FLOOR MUSCLES

Do you ever have any bladder incontinence (leaking urine)? Y / N

If so, it's when you (circle any that apply): Cough/Sneeze Jump/Run Lift/Strain

Do you have any problem holding on, on your way to the toilet? Y / N

Do you feel like you have to strain to empty your bladder or your bowels? Y / N

Do you feel any heaviness, bulging or pain in your pelvic area/vagina? Y / N

Do you have unusual pain during intercourse? Y / N

CURRENT CARE

Have you attended any Pregnancy or Postnatal exercise classes or training? Y / N

Do you currently exercise regularly? Y / N

If so, what exercises & how often? _____

Do you know how to do pelvic floor muscle exercises/kegel exercises? Y / N

When/where do you do these exercises? _____

Have you received instruction on core breathing, transversus abdominus

(TVA) contraction, &/or diaphragmatic breathing? Y / N

Do you feel you can "connect" to your abdominal muscles? Y / N

Are you receiving treatment for pelvic floor dysfunction, diastasis recti or other? Y / N

Name of care provider/physiotherapist/etc. _____

STANDARD HEALTH SCREEN

Do you now, or have you had in the past:	yes	no
• history of heart problems, chest pain or stroke	☐	☐
• increased blood pressure	☐	☐
• any chronic illness or condition	☐	☐
• advice from physician not to exercise	☐	☐
• recent surgery (last 12 months)	☐	☐
• recent injury or muscle/joint disorder	☐	☐
• history of breathing or lung problems	☐	☐
• diabetes or thyroid condition	☐	☐
• cigarette smoking habit	☐	☐
• increased blood cholesterol	☐	☐
• history of heart problems in immediate family	☐	☐
• hernia, or any condition aggravated by lifting weight	☐	☐

comments regarding above: _____

FOR TRAINER COMPLETION ONLY

___ asked to omit impact ___ asked to omit plank/pushup/weighted hinge/variations

Referral to Physiotherapist? Y / N