



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

☐ Heart Disease

☐ Cervical Stitch

☐ Dizziness/fainting

☐ Thyroid disease

☐ Reduced foetal mvt

☐ Vaginal bleeding

☐ Kidney Disease

☐ Pre eclampsia

☐ Dizziness/Faintness

☐ Placenta Previa

☐ Asthma

☐ Diabetes

☐ Multiple Pregnancy

☐ Swelling hands/feet

Discomforts (please 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: _____