



## Health and medical registration for pregnant clients

### General Information:

Name:		
Telephone	Work: Mobile:	
Date of Birth: / /	Age:	Occupation:
Address:   		
Email		

### Emergency Details:

Name of regular Doctor:		Doctors phone number:
Obstetrician/Care-giver:		Hospital:
Are you on any prescribed medication:  No <input type="checkbox"/> Yes – list medication:		
Name of contact (in case of Emergency):	Relationship to you:	Contact phone number:

### Pregnancy History:

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

Is this your first pregnancy?                      Yes                      No                      (please circle)

If no, previous pregnancy date/s \_\_\_\_\_

Type of delivery? \_\_\_\_\_

Do you have a history of miscarriages?    Yes                      No

If yes, provide details: \_\_\_\_\_

Previous complications during pregnancy?    Yes                      No

If yes, provide details: \_\_\_\_\_

### During this pregnancy have you experienced the following?

- |  |   |
|--|---|
| <input type="checkbox"/> Marked fatigue  | <input type="checkbox"/> Migraine/headache                        |
| <input type="checkbox"/> Abdominal pain  | <input type="checkbox"/> Cervical stitch                          |
| <input type="checkbox"/> Dizziness/faintness   | <input type="checkbox"/> Foetal growth retardation                |
| <input type="checkbox"/> Multiple births/pregnancy                                     | <input type="checkbox"/> Premature labour/birth                   |
| <input type="checkbox"/> Vaginal bleeding/spotting                                     | <input type="checkbox"/> Breech presentation                      |
| <input type="checkbox"/> Heart burn/gastric reflux                                     | <input type="checkbox"/> knee pain                                |
| <input type="checkbox"/> Reduced foetal movement                                       | <input type="checkbox"/> Incompetent Cervix                       |
| <input type="checkbox"/> Pelvic joint swelling   | <input type="checkbox"/> Baby smaller than expected               |
| <input type="checkbox"/> Portion of placenta over cervix                               | <input type="checkbox"/> Swelling, pain or redness in calf        |
| <input type="checkbox"/> Incontinence (altered bladder control)                        | <input type="checkbox"/> Swelling – (circle) ankles, hands, face) |
| <input type="checkbox"/> Preclampsia/pregnancy induced hypertension                    |   |
| <input type="checkbox"/> Circulatory problems (varicose veins – legs, anal or vaginal) |   |

If you have ticked any of the above, please provide details:

\_\_\_\_\_

### Medical History:

Have you or do you currently suffer from any of the following?

- |   |  |
|---|--|
| <input type="checkbox"/> Abnormal blood pressure (high/low) | <input type="checkbox"/> Respiratory disease                             |
| <input type="checkbox"/> Kidney disease                     | <input type="checkbox"/> Chest pain/ palpitations                        |
| <input type="checkbox"/> Neck pain                          | <input type="checkbox"/> Faintness/dizziness                             |
| <input type="checkbox"/> Muscular/ skeletal injury          | <input type="checkbox"/> Anaemia   |
| <input type="checkbox"/> Recent surgery/illness             | <input type="checkbox"/> Heart disease / family history of heart disease |

- |   |  |
|---|--|
| <input type="checkbox"/> Thyroid disease        | <input type="checkbox"/> Diabetes or family history of diabetes                  |
| <input type="checkbox"/> Lower back pain        | <input type="checkbox"/> Epilepsy  |
| <input type="checkbox"/> Recent viral infection | <input type="checkbox"/> Stroke  |
| <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Other problems that may affect your ability to exercise |

If you have ticked any of the above, please provide details:

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### Medication and habits:

Are you currently taking any medication?                      Yes                      No

Provide details: \_\_\_\_\_

Do you smoke?                      Yes                      No

If yes, how many per day? \_\_\_\_\_

Do you consume alcohol?                      Yes                      No

If yes, how many drinks per week? \_\_\_\_\_

### Exercise History:

Were you exercising before prior to becoming pregnant?                      Yes                      No

If so, specify type and frequency:

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Are you currently exercising?                      Yes                      No

If so, specify type and frequency:

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What goals do you hope to achieve by coming to mishfit mothers?

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Where / How did you hear about mishfit mothers?

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If you have children, where do they go to kinda, school or child-care?

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Please note that if you have ticked any of the boxes on page 2, you **MUST** get signed medical clearance before attending mishfit mothers personal training.

All information given remains confidential to mishfit personal training.

Acknowledgement and Release:

I, the undersigned acknowledge that:

1. In normal circumstances the exercises should not harm myself, or my baby, in any way.
2. I shall inform this mishfit mothers Personal Trainers of any medical or pregnancy related changes, prior to commencing any training session.
3. mishfit mothers personal training will not be liable in any way for any unseen circumstances or for any circumstances of which I should have been aware, but failed to notify them.
4. I give my permission to staff of mishfit Personal Trainers to contact any of the emergency contact numbers set out above should the need arise.
5. I am responsible for the supervision of my child/ children before, during and after the session.
6. I have read the above statements and agree to be bound by it and to release mishfit Personal Trainers from all claims.

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

Signature: \_\_\_\_\_

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