MUMS IN TRAINING

REGISTRATION FORM

Angliss, Healesville Hospital
& Yarra Valley Health

UR Number: ______________________

Surname: ______________________

Given Name: ______________________

Date of Birth: ________/________/_______ Sex: M / F

Affix Hospital ID Label If Available

PHYSIOTHERAPY MUMS IN TRAINING REGISTRATION FORM EH 124000

CONFIDENTIAL PERSONAL INFORMATION:

Name: ....

Address: ....

....

Phone: H) ....

W) ....

Date of birth: ....

Email address: ....

Doctor's Name: ....

....

Emergency contact & phone: ....

....

Medicare No/Exp: ....

Your occupation: ....

PREGNANCY INFORMATION:

1. Birth History:

- Expected Due Date: .... Current gestation: ....
- Is this your first pregnancy? YES ☐ NO ☐
  (If no, please complete the chart below…)

Year of Birth	Pregnancy term	Type of Delivery	Any problems with pregnancy?/Outcome

- Is this pregnancy / or any previous pregnancy the result of an IVF conception? YES ☐ NO ☐

2. Medical and Pregnancy Conditions:

MEDICAL CONDITIONS	YES	NO	PREGNANCY CONDITIONS	YES	NO
Known heart problems			Multiple pregnancy		
High / Low blood pressure			Incompetent cervix		
Anaemia			Vaginal bleeding		
Chest conditions (e.g. asthma, recent pulmonary embolism)			Uterine bleeding /Ruptured membranes		
Diabetes (GDM or Type1 or2)			Pre-eclampsia / Toxaemia		
Epilepsy			Poor foetal growth / Foetal distress		
Thrombrophlebitis			Breech presentation		
Excessively under or over weight			Diagnosis of placenta praevia		
Thyroid disease			Risk of premature labour		

Revised May 2017

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♦ Are you taking any medications? YES ☐ NO ☐

If yes, please give details - ....

♦ Do you currently smoke? YES ☐ NO ☐

If yes, please indicate - how many per day ……………- over how many years ....

3. Other discomforts: (please circle to be more specific where appropriate)

♦ Have you experienced any of the following: a) with this pregnancy, b) with a previous pregnancy

Involuntary loss of urine	YES ☐	NO ☐
Backache	YES ☐	NO ☐
Pain / numbness / tingling in arms or legs	YES ☐	NO ☐
Pelvic joint pain	YES ☐	NO ☐
Heartburn	YES ☐	NO ☐
Fluid retention	YES ☐	NO ☐
Varicose veins / haemorrhoids	YES ☐	NO ☐
Headaches / dizziness	YES ☐	NO ☐
Neck / shoulder pain	YES ☐	NO ☐

GENERAL FITNESS:

♦ Do you currently participate in any specific form of exercise? YES ☐ NO ☐

If yes, please give details regarding type & frequency ....

....

♦ Were you exercising prior to your pregnancy? YES ☐ NO ☐

If yes, please give details ....

♦ Describe your general health prior to pregnancy:

(e.g. 100%/well/average/poor) ....

♦ Is your Doctor/Midwife aware you are exercising? YES ☐ NO ☐

♦ Please sign if your Doctor/Midwife is happy for you to exercise______________________

♦ How did you hear about the 'Mums In Training' classes? ....

☐ **I give consent to this program being run via the platform Zoom whereby my voice and image will be on a screen for the physio and other participants to see during the class.** NB. This class will not be recorded by Eastern Health or made available to anyone not participating in the program.

☐ **I agree not to take screenshots of this program or record it on my device**

These 'Mums In Training' classes are designed for safe exercise during your pregnancy. Under normal circumstances, none of the exercises in the program should cause any danger to you or your baby. The physiotherapist cannot assume responsibility for any unseen circumstances.

If your medical or physical condition changes from that described, you must notify the physiotherapist before continuing your classes.I have read the above and undertake to inform the physiotherapist should there be any changes to my medical or physical condition, before participating in these exercise classes.

Signature: .... Date: ....

Physiotherapist: .... Date: ....

Modifications: ....