



HI PILATES PRENATAL AUTHORISATION TO EXERCISE

STEPS TO COMPLETE THIS FORM

- FILL UP CLIENT DETAILS SECTION BELOW
- CONSULT YOUR FAMILY DOCTOR OR GENERAL PRACTITIONER AND HAVE THEM FILL UP THEIR ASSESSMENT ON SUBSEQUENT PAGES
- BRING THE COMPLETED FORM TO YOUR PRENATAL WORKOUT AND SUBMIT IT TO YOUR TRAINER.

CLIENT DETAILS

FULL NAME

ADDRESS LINE 1

SUBURB

STATE

POSTCODE

PHONE NUMBER

EMAIL ADDRESS

SPECIALIST DETAILS

FULL NAME

ADDRESS LINE 1

SUBURB

STATE

POSTCODE

PHONE NUMBER

EMAIL ADDRESS



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ABSOLUTE CONTRAINDICATIONS

KINDLY INFORM US BY MARKING THE WHITE BOX IF THE CLIENT HAS THE FOLLOWING ABSOLUTE CONTRAINDICATIONS TO EXERCISE DURING THEIR PREGNANCY.

• RUPTURED MEMBRANES	YES <input type="checkbox"/>	NO <input type="checkbox"/>
• PRETERM LABOUR	YES <input type="checkbox"/>	NO <input type="checkbox"/>
• HIGH BLOOD PRESSURE DISORDERS OF PREGNANCY INCOMPETENT CERVIX	YES <input type="checkbox"/>	NO <input type="checkbox"/>
• GROWTH RESTRICTED FOETUS	YES <input type="checkbox"/>	NO <input type="checkbox"/>
• TRIPLETS OR MORE	YES <input type="checkbox"/>	NO <input type="checkbox"/>
• PLACENTA PREVIA AFTER 26 WEEKS	YES <input type="checkbox"/>	NO <input type="checkbox"/>
• PERSISTENT 2ND OR 3RD TRIMESTER BLEEDING	YES <input type="checkbox"/>	NO <input type="checkbox"/>
• UNCONTROLLED TYPE 1 DIABETES, THYROID DISEASE	YES <input type="checkbox"/>	NO <input type="checkbox"/>
• ANY OTHER SERIOUS CARDIOVASCULAR, RESPIRATORY OR SYSTEMIC DISORDER	YES <input type="checkbox"/>	NO <input type="checkbox"/>



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RELATIVE CONTRAINDICATIONS

KINDLY INFORM US BY MARKING THE WHITE BOX IF THE CLIENT HAS THE FOLLOWING RELATIVE CONTRAINDICATIONS TO EXERCISE DURING THEIR PREGNANCY.

• PREVIOUS MISCARRIAGES PREVIOUS PRETERM BIRTH	YES <input type="checkbox"/>	NO <input type="checkbox"/>
• MILD/MODERATE CARDIOVASCULAR DISORDER	YES <input type="checkbox"/>	NO <input type="checkbox"/>
• MILD/MODERATE RESPIRATORY DISORDER	YES <input type="checkbox"/>	NO <input type="checkbox"/>
• ANEMIA (HB <100G/L)	YES <input type="checkbox"/>	NO <input type="checkbox"/>
• MALNUTRITION OR EATING DISORDER	YES <input type="checkbox"/>	NO <input type="checkbox"/>
• TWIN PREGNANCY > 28 WEEKS	YES <input type="checkbox"/>	NO <input type="checkbox"/>
• OTHER SIGNIFICANT MEDICAL CONDITIONS	YES <input type="checkbox"/>	NO <input type="checkbox"/>

WARNING SIGN

KINDLY ADVISE THE CLIENT OF THESE WARNING SIGNS THAT EXERCISE SHOULD CEASE IMMEDIATELY.

- VAGINAL BLEEDING
- CALF PAIN OR SWELLING
- CHEST PAIN
- HEADACHE
- DYSPNOEA BEFORE EXERTION
- ONSET OF LABOUR
- MUSCLE WEAKNESS
- DECREASED FOETAL MOVEMENT
- DIZZINESS



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ADDITIONAL COMMENTS

KINDLY INPUT ADDITIONAL COMMENTS RELATED TO THIS CLIENT'S PREGNANCY & EXERCISE PLAN.

RECOMMENDATION

KINDLY ADVISE THE CLIENT OF THESE WARNING SIGNS THAT EXERCISE SHOULD CEASE IMMEDIATELY.

- HAVING CONSIDERED ALL THE CONTRAINDICATIONS AND WARNING SIGNS ON THIS FORM, KINDLY PROVIDE YOUR RECOMMENDATION ON WHETHER OR NOT THE CLIENT IS FIT TO EXERCISE AT HI PILATES.
- DO YOU RECOMMEND THIS CLIENT TO EXERCISE AT HI PILATES DURING THEIR PREGNANCY? YES NO