POSTNATAL ASSESSMENT FORM

Full Name: _____

Physical Address: _____

Telephone Numbers:

- Home: _____ Work: _____
- Cell: _____ Partner's cell: _____

Email: _____

Dr's Name: _____

Dr's contact number/s: _____

Birthing History:

- What type of birth did you have? Vaginal/C-Sec on
- Complications? If yes, provide further information on

  _____

  _____

- DOB of Baby: _____
- Are you currently breast-feeding? Yes/No
- Diastasis Measurements:

  5 days postnatal: _____

  First session measurement: _____

WEEK	WIDTH	DEPTH	LENGTH
2nd Week			
4th Week			
8th Week			
10th Week			
12th Week			
14th Week			

(Continued assessment if required)

• What is your current lifestyle related to the healing of your diastasis?

_____

The participant's signature hereto acknowledges that, whilst every precaution is taken, the Pilates teacher cannot be held responsible for any injuries incurred during or as a result of the Pilates lesson or whilst on the teacher’s property and accordingly indemnifies the teacher from any claims that may arise against her therefrom.

Client Signature: _____ Date: _____

Full Name: _____ Date: _____