INTEGRATED POST NATAL PHYSIOTHERAPY & FUNCTIONAL FITNESS

Mummy MOT® Pre Assessment

What are your three top concerns/goals to achieve?

1)

2)

3)

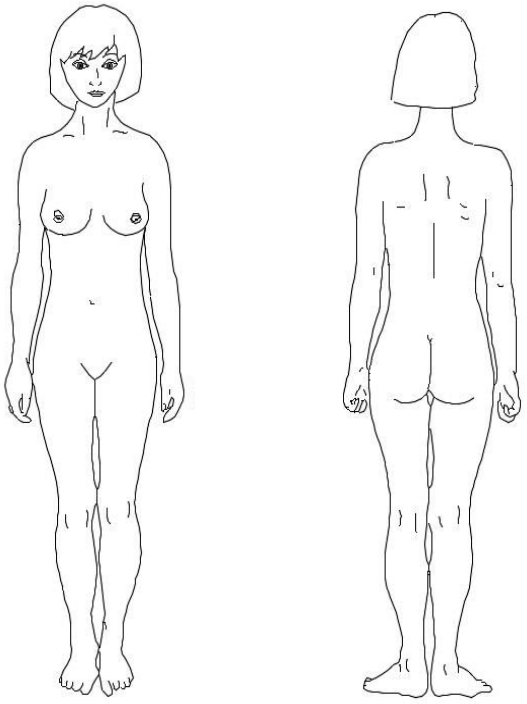
Please complete the table below as fully as possible.

Child	D.o.B	Method of delivery	Complications?	Weight of baby at birth	Concerns post delivery
1					
2					
3					

Are you currently breastfeeding? ✢ Yes ✢ No

MUSCULOSKELETAL PROBLEMS

Please highlight any areas of pain or discomfort on the body chart you are experiencing presently?



Please list up to three activities, movements or positions that bring on your pain/problem? (e.g. Lifting, running, sitting)

1)

2)

3)

WHAT ARE YOUR MAIN CONCERNS (Please circle all that apply)

Gap in tummy muscles (diastasis)	Sexual Concerns	Anxiety	Mood imbalance
Bladder Problems	Musculoskeletal problems	Pelvic Girdle Pain	Sleep Deprivation
Bowel issues	Prolapse	Pain on intercourse	Back Pain
Any Other Concerns			

URINARY SYMPTOMS (Please circle all that apply)

Urinary frequency (going often)	Pain on passing urine	Reduced flow of urine	Urinary urgency (rushing to go)
Leaking	UTIs (infections)	Problems emptying your bladder completely	Stress incontinence (leaking on cough, exercise etc)

BOWEL SYMPTOMS (Please circle all that apply)

Urgency	Constipation	Not feeling that you empty your bowels completely
Leaking	Pressure on the rectum	Assistance to empty your bowels
Pain on opening bowels		

DIASTASIS

Do you feel a gap between your tummy muscles?	Yes	No
Do you have difficulty activating your tummy muscles?	Yes	No
Are you struggling to regain your core?	Yes	No

PELVIC FLOOR SYMPTOMS

Do you experience discomfort in your vagina or rectum? (back passage)?	Yes	No
Have you been diagnosed with a prolapse now or in the past?	Yes	No
Do you have pain during intercourse?	Yes	No
Do you have discomfort inserting or wearing tampons?	Yes	No
Do you have pain sitting?	Yes	No
Do you experience pins and needles or numbness in the area?	Yes	No
Do you feel any swelling?	Yes	No

PAST MEDICAL HISTORY

Have you had any Gynecological or urological surgery?	Yes	No
Date(s) and type of surgery/reason?		
Have symptoms fully resolved?	Yes	No
Do you have any abdominal scars?	Yes	No
Describe where scars are:		
Please state any fractures with dates		

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS

Connective tissue disorders (eg Lupus)	Hypermobility syndromes (eg Ehlers Danlos)	Thyroid disease
Heart problems	Respiratory problems	Diabetes Type 1 or 2
Cancer	Bowel conditions (IBS/colitis)	Endometriosis
Coccyx injuries	Back pain	
Any other conditions you are being treated for		

MEDICATIONS INCLUDING SUPPLEMENTS

Have you ever been on a course of steroid treatment?	Yes	No
Have you ever been on Warfarin or blood thinning medications (eg for blood clots)?	Yes	No
Any other medications/supplements	Yes	No
Details of medication(s):		

CURRENT PELVIC FLOOR EXERCISE

How often are you currently practicing pelvic floor exercises?	Yes	No
Are you confident you are doing them correctly?	Yes	No

ANY OTHER COMMENTS

We hope that we can help you recover from any of the conditions you present with today. Thank you for booking your Mummy MOT®