



Lifting Baby

Postpartum Client Intake Form

Client Information

Full Name

Date of Birth

Phone Number

Email

Emergency Contact Name

Emergency Contact Phone

Delivery Details

Baby's Birth Date

Type of Delivery (Vaginal, Cesarean, Assisted)

Any delivery complications?

Medical History

Cleared to exercise:

Yes

No

Conditions:

Diastasis Recti

Pelvic Pain

Urinary Incontinence

Other:

Goals & Concerns

Fitness Goals

Movements to avoid / concerns

Current Activity Level

Not currently active

Light movement (e.g., walking)

Structured workouts

Preferred Training Format

In-Person Sessions

Virtual Coaching

Combination



Lifting Baby

Liability Waiver & Release Form

Fillable participant waiver for in-person or digital signing

Important Information

The information provided by **Lifting Baby**, its website, and affiliated programs is intended for general guidance only and is not a substitute for professional medical advice.

Always seek the advice of your physician or other qualified health provider with any questions you may have regarding a medical condition, pregnancy, postpartum recovery, or readiness for exercise.

Participation Risk and Liability

Participation in any physical exercise program involves risk. Lifting Baby is not liable for any injuries or health issues that may result from use of our programs, classes, or materials.

By continuing with our services, you acknowledge that you understand these risks and agree to participate voluntarily.

Acknowledgment

By signing below, I confirm that I have read and understood this disclaimer, I understand that Lifting Baby does not provide medical advice, and I accept responsibility for my participation.

Participant Information

Full Name

Signature

Date

Print Name



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Health & Fitness Disclaimer

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Participant Signature

Date

Print Name



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Postpartum Mental Health Questionnaire

Your responses are private and help us better support you safely.

In the past 7 days, please select the response that best describes how you have felt:

1. I have looked forward with enjoyment to things.

Yes, most of the time

Yes, some of the time

No, not much

No, never

2. I have blamed myself unnecessarily when things went wrong.

Yes, most of the time

Yes, some of the time

No, not much

No, never

3. I have been anxious or worried for no good reason.

Yes, most of the time

Yes, some of the time

No, not much

No, never

4. I have felt scared or panicky for no very good reason.

Yes, most of the time

Yes, some of the time

No, not much

No, never

5. I have been so unhappy that I have had difficulty sleeping.

Yes, most of the time

Yes, some of the time

No, not much

No, never

If you are experiencing postpartum anxiety or depression, please contact a licensed provider or visit www.postpartum.net for additional resources.



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Prenatal Exercise Physician's Consent Form

Patient Information

Patient Name

Date of Birth

Expected Due Date

Physician Approval

I certify that the above-named patient is under my care and is medically cleared to participate in a prenatal fitness program with modifications as necessary.

Recommendations / Restrictions

Physician Information

Physician Name

Phone

Email

Date

Signature