Postnatal Questionnaire for Moms

Name ______________________________ Date __________________

Baby's Name ____
Date of Birth ____

How many weeks postpartum ____________

Type of Delivery: _______Vaginal Delivery ________C-Section

____

If vaginal delivery, any significant tearing or trauma to the perineum __________

____

What are the current restrictions on movement given to you by your doctor, midwife, Doula ____

____

Any bleeding with activity ____

Do you have diastasis recti (separation of abdominal muscles) ____________

If yes, current activity restrictions __________________________________

____

Any other pain in body _______ Where ___________________________

Intensity of pain/discomfort ______________________________________

Frequency of pain/discomfort _____________________________________

Any concerns ____

Save file using "Save As" before closing. Include your name on the file name. Send completed form to: office@5koshasyoga.com and reneepeterson2121@gmail.com.