

# GET ACTIVE QUESTIONNAIRE FOR POSTPARTUM



NAME (+ NAME OF PARENT/GUARDIAN IF APPLICABLE) [PLEASE PRINT]:

TODAY'S DATE (DD/MM/YYYY):

DATE OF DELIVERY (DD/MM/YYYY):

NO. OF WEEKS POSTPARTUM:

AGE:

Physical activity after childbirth has many health benefits and is generally safe for you and your baby. But for some conditions, physical activity is not recommended. This questionnaire is designed to help you to determine whether you should speak to your primary health care provider (e.g., your physician or midwife) before you begin or continue to be physically active.

Please answer each question to the best of your ability by circling Y for Yes or N for No. **If your health changes at any point in the 12 months after childbirth you should complete this questionnaire again.**

1.	In the first year after childbirth, have you experienced any of the following?		
	a. Loss of consciousness for any reason?	Y	N
	b. Neurological symptoms such as poor coordination or muscle weakness affecting balance?	Y	N
	c. Deep vein thrombosis (blood clot in legs; can cause leg pain and swelling, or red/warm skin around painful area) or pulmonary emboli (blood clot in lungs; can cause shortness of breath, dizziness)?	Y	N
	d. High blood pressure ( $\geq 140/90$ mmHg) that is not stable?	Y	N
	e. An eating disorder(s) or malnutrition?	Y	N
	f. Postpartum cardiomyopathy (heart disease after childbirth)?	Y	N
	g. New symptoms of heart disease (e.g., chest pain or discomfort) or stroke (e.g., face drooping, slurred speech) during activities of daily living or at rest?	Y	N
	h. Severe abdominal pain?	Y	N
	i. Chest pain/discomfort, dizziness or lightheadedness during exercise?	Y	N
	j. Breathing difficulties such as shortness of breath at rest that does not improve with medications?	Y	N
	k. Kidney disease?	Y	N
	l. Excessive fatigue (e.g., beyond tiredness, does not improve with rest)?	Y	N
	m. Severe infection accompanied by fever, body aches, or swollen lymph glands?	Y	N
	n. Broken bone(s) or another significant injury?	Y	N
	o. Caesarean section pain that worsens with exercise (e.g., surgical incision pain)?	Y	N
	p. Vaginal bleeding not associated with menses?	Y	N
2.	Do you have any other medical condition that may affect your ability to be physically active following childbirth? What is the condition? Please specify:	Y	N
3.	Are you concerned about returning to, or increasing your physical activity following childbirth? Please explain:		

**Go to Page 2 Describe Your Physical Activity Level**

# Describe Your Physical Activity Level

During a typical week, what types of physical activities do you take part in (e.g., swimming, walking, resistance training, yoga)?

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During the same week, please describe ON AVERAGE how often and for how long you engage in physical activity of a light, moderate or vigorous intensity. See definitions for intensity below the box.

ON AVERAGE	FREQUENCY (times per week)	INTENSITY (see below for definitions)	DURATION (minutes per session)
How physically active were you in the <b>six months before pregnancy?</b>	<input type="checkbox"/> 0 <input type="checkbox"/> 3-4 <input type="checkbox"/> 1-2 <input type="checkbox"/> 5-7	<input type="checkbox"/> light <input type="checkbox"/> moderate <input type="checkbox"/> vigorous	<input type="checkbox"/> <20 <input type="checkbox"/> 31-60 <input type="checkbox"/> 20-30 <input type="checkbox"/> >60
How physically active are you <b>currently?</b>	<input type="checkbox"/> 0 <input type="checkbox"/> 3-4 <input type="checkbox"/> 1-2 <input type="checkbox"/> 5-7	<input type="checkbox"/> light <input type="checkbox"/> moderate <input type="checkbox"/> vigorous	<input type="checkbox"/> <20 <input type="checkbox"/> 31-60 <input type="checkbox"/> 20-30 <input type="checkbox"/> >60
What are your physical activity goals for the <b>next six months?</b>	<input type="checkbox"/> 0 <input type="checkbox"/> 3-4 <input type="checkbox"/> 1-2 <input type="checkbox"/> 5-7	<input type="checkbox"/> light <input type="checkbox"/> moderate <input type="checkbox"/> vigorous	<input type="checkbox"/> <20 <input type="checkbox"/> 31-60 <input type="checkbox"/> 20-30 <input type="checkbox"/> >60

**Light intensity physical activity:** You are moving, but you do not sweat or breathe hard, such as walking to get the mail or light gardening.

**Moderate intensity physical activity:** Your heart rate goes up and you may sweat or breathe hard. You can talk, but could not sing. Examples include brisk walking.

**Vigorous intensity physical activity:** Your heart rate goes up substantially, you feel hot and sweaty, and you cannot say more than a few words without pausing to breathe. Examples include fast stationary cycling and running.

## General Advice for Being Physically Active in the First Year Postpartum

Follow the advice in the 2025 Canadian Guideline for Physical Activity, Sedentary Behaviour and Sleep throughout the First Year Postpartum which recommends following an individualized, gradual and symptom-based progression towards the goal of at least 120 minutes of moderate-to-vigorous intensity physical activity (resistance training, brisk walking, swimming, gardening), spread over four or more days of the week: [csep.ca/getactivequestionnaire-postpartum](https://csep.ca/getactivequestionnaire-postpartum)

We recommend everyone be screened (and treated) for barriers to physical activity: mental health, pelvic floor and abdominal wall function, musculoskeletal pain, wound healing, excessive fatigue, poor sleep, fear of movement, lactation status, social/emotional support, & eating disorders. If you have any questions about postpartum physical activity, consult a Qualified Exercise Professional or your healthcare provider to help ensure that your physical activity is safe and suitable for you.

## Declaration

To the best of my knowledge, all of the information I have supplied on this questionnaire is correct.

**If my health changes, I will complete this questionnaire again.**

I answered **NO** to all questions on Page 1.

*Sign and date the declaration below.  
Physical activity is recommended.*

**I answered YES to one or more questions on Page 1 and I will speak with my health care provider before beginning or continuing physical activity.**

I have spoken with my health care provider who has recommended that I take part in physical activity during the postpartum period. If my health changes I will speak with them again.

*Sign and date the declaration below.*

NAME (+ NAME OF PARENT/GUARDIAN IF APPLICABLE) [PLEASE PRINT]:		SIGNATURE (OR SIGNATURE OF PARENT/GUARDIAN IF APPLICABLE):
TODAY'S DATE (DD/MM/YYYY):	TELEPHONE (OPTIONAL):	EMAIL (OPTIONAL):