THE
PELVIC
CONNECTION

EMPOWERED HEALTH

Physical Therapy
Intake Form

Introduction

Your Name:

Preferred Name:

Age:

Occupation:

Known allergies:

Briefly describe your current symptoms (Including how it started)

What affects your symptoms (e.g., any position, activity, rest, weather, etc.)

Makes symptoms better:

Makes symptoms worse:

Medical history

Conditions you are presently being treated for:	
Conditions you were treated for in the past	
Any surgical history	
Medications you are on	

Medical history in chronological order

(Describe how your symptoms started, what treatment you have taken for it, how your symptoms have changed over a period of time, and what additional symptoms you are experiencing now)

Your goals and expectations from physical therapy

Functional Goals (in terms of physical activities/ abilities)	
Expectations from your PT (how can I best assist you in reaching your goals?	
Any Concerns about your PT sessions	
How much time (e.g. hrs/week) **will you realistically be able to devote to PT?**	

Pelvic health related questions (check all that apply)

Bladder Health	Bowel Health	Sexual Health
Difficulty in initiating the urine stream ☐	Chronic constipation: Go to the bathroom less than 3 times a week ☐	Burning, itching, feeling of dryness in the vulvar, scrotal, perineal, or anal region. ☐
Incomplete emptying of the bladder ☐	incomplete emptying of the bowels ☐	Pain in the vulvar, scrotal, perineal, or the anal region ☐
Straining to pee ☐	Straining to pass a bowel movement ☐	Pain with intercourse: deep vs superficial ☐
Dribbling after peeing or urinary leakage with sneeze/laugh/cough ☐	Fecal smearing ☐	Feeling of hitting a wall during intercourse ☐
Painful urination ☐	Painful Bowel movement ☐	Pain with orgasm or pain with ejaculation ☐
Constant and frequent urge to pee ☐	Sudden urge to poop ☐ leading to leakage at times	
Frequency of urination during the day and at night: Day: ☐ Night: ☐	Frequency of bowel movement in a day & average in the week: Day: ☐ Week: ☐	

Email	Phone Number

CONSENT FOR EVALUATION AND TREATMENT

Informed consent for treatment. The term "***informed consent***" means that the potential risks, benefits, and alternatives of physical therapy evaluation and treatment have been explained to you. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the evaluation, treatment, and options available for my condition.

I also acknowledge and understand that l have been referred for **evaluation and treatment** of pelvic floor dysfunction. Pelvic floor dysfunctions include but are not limited to, urinary or fecal incontinence, difficulty with bowel, bladder, or sexual functions, painful scars after childbirth or surgery, persistent sacroiliac or low back pain, or pelvic pain conditions.

I understand that to **evaluate** my condition it may be necessary, initially and periodically, to have my therapists perform an internal pelvic floor muscle examination. This examination is performed by observing and/or palpating the perineal region including the vagina and/or rectum. This evaluation will assess skin condition, reflexes, muscle tone, length, strength and endurance, scar mobility, and function of the pelvic floor region. I will have the opportunity to give/revoke my consent at each treatment session.

Treatment may include, but is not limited to the following: observation, palpation, use of vaginal weights, vaginal or rectal sensors for biofeedback and/or electrical stimulation, ultrasound, heat, cold, stretching and strengthening exercises, external and/or internal soft tissue and/or joint mobilization and educational instruction.

If you consent, you have the option to have a second person in the room for the pelvic floor muscle evaluation and treatment (as described above). The second person could be a friend, family member, or clinic staff member. Please indicate your preference with your initials:

☐_____ YES I want a second person present during the pelvic floor muscle evaluation and treatment.

☐_____ NO I do not want a second person during the pelvic floor muscle evaluation and treatment.

☐_____ I would like to discuss my options with my physical therapist prior to consenting.

Potential risks: I may experience an increase in my current level of pain or discomfort or aggravation of my existing injury. This discomfort is usually temporary; if it does not subside in 1-3 days, I agree to contact my therapist.

Potential benefits: may include an improvement in my symptoms and an increase in my ability to perform my daily activities. I may experience increased strength, awareness, flexibility, and endurance in my movements. I may experience decreased pain and discomfort. I should gain greater knowledge about managing my condition and the resources available to me.

Release of medical records: I authorize the release of my medical records to my physicians/primary care provider or insurance company.

Cooperation with treatment: I understand that in order for therapy to be effective, I must come as scheduled unless there are unusual circumstances that prevent me from attending therapy. I agree to cooperate with and carry out the home program assigned to me. If I have difficulty with any part of my treatment program, I will discuss it with my therapist.

No warranty: I understand that the physical therapist cannot make any promises or guarantees regarding a cure for improvement in my condition. I understand my therapist will share with me her opinions regarding the potential results of physical therapy for my condition and will discuss all treatment options with me before I consent to treatment.

****I have informed my therapist of any condition that would limit my ability to have an evaluation or be treated**.** I hereby request and consent to the evaluation and treatment to be provided**.**

Patient Name (please print) _____

Patient Signature _____ **Date** _____

Witness Signature_____**Date** _____

****If you are pregnant, have an infection of any kind, have an IUD or other implants, have a sexually communicable disease, are less than **6** weeks postpartum or post**-**surgery, have severe pelvic pain, sensitivity to lubricant, vaginal creams or latex, please inform the therapist prior to the pelvic floor assessment**.**

What can you 'expect' from your first session?

1. Please bring comfortable/ loose clothing — loose shorts and a T-shirt is great. Tights are comfortable clothing, but they do limit the assessment of joints and muscles properly, so please avoid them.
2. I will discuss your medical history in detail, if you could go over your medical history and write it down in chronological order that usually is extremely helpful for connecting different aspects of your health.
3. There is no such thing as too much information (TMI). You do not need to apologize for sharing intimate details. I welcome information and ask questions about your pee, poo, and sex life to understand what might be causing your issues.
4. I will then do a comprehensive assessment of your:
   - ☐ Musculoskeletal systems - Assessment of mobility, strength, endurance, and flexibility of muscles, bones, joints, fascia, etc.
   - ☐ Organ system- abdominal and pelvic organs, diaphragm
   - ☐ Respiratory system- rib cage mobility, diaphragmatic movement, breathing, etc.
   - ☐ Pelvic floor system- pelvic floor muscles, ligaments, and tailbone assessment can be done both vaginally or rectally depending on your issue. And I would not perform the assessment without explaining the process in detail.
   - ☐ Posture and movement assessment
   - ☐ Nervous system assessment-

(for more details on my assessment style, please visit my website here)

5. After the assessment, I would gather all the information from your medical history, your current complaints, and my examination and provide you a clear picture of the potential root cause of your issue and then, together, we will create a plan of care for you based on your goals and wishes.

6. Depending on the time left, I may show you a few exercises to do at home to get started. However, the first session is mainly focused on the assessment, education, and creating a plan of care that we both agree on.

Cancellation Policy

I am aware that things come up and during the course of treatment, you may need to cancel/reschedule an appointment. However, please provide adequate notice (24 business hours), so I can utilize the time for another client in need.

If you are running late, please know that I may not be able to provide you with the entire 60 min session as I may have to attend to another client right after you. I would also appreciate if you could let me know if you are running late.

Clients are charged a late cancellation fee and no-shows on the day of the appointment. If you are ill or have an emergency, I will be happy to consider this on an individual basis.

- Late cancellation = less than 24-hour notice
- No Show = canceling < 2 hours before the appointment or no show/no call
- Late arrival = more than 5 minutes late to appt. May have to shorten our session

Fees

- Late cancellation – $75 first incident; $100 subsequent incident
- No show – $100 per incident

Patient Name (please print) _____

Patient Signature _____ **Date** _____