MOORE
PHYSICAL THERAPY

# PELVIC FLOOR PATIENT INTAKE FORM

**NAME: _____ DATE: _____ DOB_____ Sex M/F**

## PATIENT HISTORY

**A. Please describe the current problem that brought you here?**

_____
_____
_____

**B. When did your problem first begin?**

_____
_____
_____

**C. Have you ever received treatment for this condition or symptoms before? If so, what? And did it help?**

_____
_____
_____

**D. Please list any abdominal/pelvic surgeries you have had in the past:**

_____
_____
_____

**E. Please list any medications (including supplements) that you are currently taking:**

_____
_____
_____

**F. Please list any other ongoing medical conditions you are currently being treated for?**

_____
_____
_____

**G. Are you currently pregnant or do you have any history of pregnancies?** Yes/No **If so, how many? _____**

**H. Many people have experienced physical, emotional, and/or sexual abuse which could contribute to pelvic floor dysfunction. Is this something that you may have experienced in the past and/or are currently experiencing now and would be willing to share?**

_____
_____
_____

**I. What are your goals for physical therapy?**

_____
_____
_____

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# INTERNAL PELVIC FLOOR EVALUATION & TREATMENT CONSENT FORM

**Informed Consent for An Evaluation and Treatment:** The purpose of an internal pelvic floor evaluation and treatment is to conduct an examination of the internal pelvic floor musculature to determine if there are any existing pelvic floor dysfunction(s) in order to develop an appropriate and individualized plan of care post-examination for treatment. Pelvic floor dysfunctions include but are not limited to: urinary or fecal incontinence, difficulty with bowel or bladder functions, sacroiliac functions, sexual dysfunction, and/or pelvic pain conditions.

**Internal Pelvic Floor Evaluation:** The internal pelvic floor evaluation will consist of: (1) visual inspection of the perineal body and ability to locate, coordinate, and incorporate appropriate pelvic floor muscles during contraction, relaxation, and bulging; (2) palpation of the perineal body to assess for symptoms; (3) insertion of ONE gloved finger with a water-based lubricant into the perineal region including the vagina and/or rectum to assess muscle tone, length, strength, endurance, scar mobility, and function of the pelvic floor region.

**Treatment:** Treatment may include but are not limited to internal trigger point releases, contraction and endurance-training, stretching and strengthening exercises, internal and/or soft tissue and/or joint mobilization, relaxation and breathing techniques, and educational instructions.

Treatments may also include use of a pelvic wand and/or vaginal dilators. If you are interested in purchasing a pelvic wand and/or vaginal dilators for your treatment, your therapist will assist you in ordering them or you may purchase one from the clinic.

**Potential Risks:** Some potential risks may include but are not limited to an increase in current level of pain or discomfort, aggravation of existing injury or emotional distress. These effects are usually temporary; if it does not subside within 1-3 days, I agree to contact my pelvic floor physical therapist specialist and/or physician.

> **Note:** If you are currently pregnant or suspect that you are pregnant, have infections of any kind, a sexually communicable disease, IUD or other implants, or are less than 6 weeks postpartum or post-surgery, please inform your physical therapist prior to receiving the internal pelvic floor evaluation and treatment.

I have informed my pelvic floor physical therapist specialist of any condition that would limit my ability to undergo an internal pelvic floor evaluation and/or to be treated internally. _____ Initial here

**Potential Benefits:** The potential benefits of receiving an internal pelvic floor evaluation may include but are not limited to a more in-depth understanding regarding the current function of my pelvic floor muscles, 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 a greater knowledge about managing my condition and the resources available to me.

**No Warranty:** I understand that the therapist(s) cannot make any promises or guarantees regarding a cure for or improvement of my condition. I understand that my therapist(s) will share their opinion with me regarding potential results of physical therapy and will discuss all treatment options with me before I consent to treatment.

**Chaperone Policy:** I understand that I have the option of bringing a spouse, family member, friend, or available clinical staff member with me during my visits if it makes me feel more comfortable having a second person in the room with me. Otherwise, I understand that I can decline this option. _____ Initial here

By signing below, I hereby request and give consent to receive the internal pelvic floor evaluation and treatment. I acknowledge that I have read this consent form and understood its terms. I understand that I may withdraw at any time before or during the evaluation and/or treatment:

| _____ | _____ | _____ |
|---|---|---|
| **Print Patient's Name** | **Patient's Signature** | **Date** |