

Patient Registration Form – Male Medicare Pelvic Health

Patient Name:		Preferred:	
Address, City, State, Zip:			
DOB:		Social Security #:	
Email Address:			
Home Phone:		Appointment Reminder Method	
Cell Phone:		<input type="checkbox"/> Home Phone	<input type="checkbox"/> Cell Phone
Work Phone:		<input type="checkbox"/> Work Phone	<input type="checkbox"/> Email
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		Partner's Name:	
Financial Responsibility: <input type="checkbox"/> Self <input type="checkbox"/> Other Please List:			
2nd Contact Name/Address:			
2nd Contact Phone:		Relation:	
General Physician:		Referred By:	
Have you had Physical Therapy treatment since January of this year? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, # of Visits:			
Have you had Chiropractic treatment since January of this year? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, # of Visits:			
Have you had Home Healthcare in the last 30 days? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, Home Healthcare Provider:			

INSURANCE INFORMATION Please Note: A copy of your insurance card(s) will be kept on file. The patient is responsible to provide their most current insurance information.			
Primary Insurance:		Secondary Insurance:	
Group #:	Policy #:	Group #:	Policy #:
Insured Information:		Insured Information:	

Consent to Treat/Assignment of Benefits/Acknowledgements	
<p>I hereby authorize and consent to treatment/services for myself, or on behalf of the above-named patient performed by the staff at Lake Centre for Rehab (LCR) and/or as directed by my referring provider. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including risk or alternatives to the recommended treatment plan.</p> <p>I assign payment for these services directly to LCR. I authorize the filing of claims to my insurance plan and authorize LCR to release necessary health information related to these services to process the claims. I certify that the information I have provided is accurate and complete.</p> <p>In signing this form, I will promptly pay any required co-pay, coinsurance and/or deductible amounts. I accept that insurance plans may deny payments for what I believe were covered services, resulting in my responsibility for paying for these services.</p> <p>I acknowledge that I have received the Notice of Privacy Practices, which describes the ways the practice may use or disclose my healthcare information. I understand that my healthcare information may be used for treatment, payment, healthcare operations and other permitted uses or disclosures as described in the Notice.</p>	
<hr style="border: none; border-top: 1px solid black;"/> Signature of Patient/Guardian	<hr style="border: none; border-top: 1px solid black;"/> Date
<hr style="border: none; border-top: 1px solid black;"/> Print Name	<hr style="border: none; border-top: 1px solid black;"/> Relationship to the Patient

Patient name:
DOB:
Authorization for Communication

By providing my above contact information and signing below, I consent and authorize LCR and its related entities, agents, contractors, including but not limited to scheduling, billing, and other departments to use automated telephone dialing systems, SMS text messaging, (if opted in) and electronic mail to (1) provide messages (including prerecorded messages or text messages, (if opted in)) to me about appointment reminders, patient surveys, my account, payment due dates, missed payments, information for or related to medical goods and/or therapy services provided, exchange information, changes to health care law, health care coverage, care follow-up, and other healthcare information or (2) provide messages (including pre-recorded messages) during a call or via text message, (if opted in) that delivers a 'health care' message made by, or on behalf of, a 'covered entity' or its 'business associate' as those terms are defined in the HIPAA Privacy Rule, 45 CFR 160.103. I understand that providing a telephone number and/or email address is not a condition of receiving medical services.

I also understand that I may revoke my consent to contact at any time by directly contacting LCR or using the opt-out method that will be identified in the applicable communication. I also understand that it is my responsibility to notify LCR immediately of any change in telephone number or email address.

Please check the box below to opt in to receive messaging.

- I consent** to receiving text messages about care, appointment reminders, and important health reminders from LCR at the phone number I provided. I acknowledge that my consent is not a condition of purchase. Message & data rates may apply. Message frequency varies. You can reply HELP for support or STOP to opt out of receiving messages. To learn more about how we handle your data please view our privacy policy [here](https://golcr.com/wp-content/uploads/sites/5/2026/03/LCR-Website-Privacy-Policy-Terms-11-2025.pdf).

<https://golcr.com/wp-content/uploads/sites/5/2026/03/LCR-Website-Privacy-Policy-Terms-11-2025.pdf>

- I do not** consent to receiving text messages.

Patient/Guardian Signature:

Date:

Release of Information

I hereby authorized LCR to discuss my personal healthcare information regarding my treatment including diagnosis/prognosis and/or billing and payment for services rendered on my behalf to the person(s) listed below.

Name (print)

Relationship

Phone number

Name (print)

Relationship

Phone number

Name (print)

Relationship

Phone number

Patient/Guardian Signature:

Date:

Financial Policy
Payment for services is due at the time services are rendered

We will verify your benefits with your insurance carrier. However, this does not guarantee that they will cover the prescribed treatment. By signing below, you are acknowledging that you are responsible for deductibles, copays, coinsurance, and non-covered services not paid by the insurance carrier and understand that you are fully responsible for any balance due for services rendered.

Patient/Guardian Signature:

Date:



Patient name:

DOB:

Cancellation/No Show Policy and Fee Acknowledgement

It is the policy of LCR to monitor and manage appointment no-shows and late cancellations. Regular attendance at therapy sessions is crucial for you to recover fully and return to the activities you love. When an appointment is missed, it's a missed opportunity for progress in your recovery, and it impacts our ability to accommodate other patients who may need urgent care.

If you need to cancel or reschedule, please call the clinic.

Scheduled appointments must be cancelled or rescheduled at least 24 hours prior.

Failure to attend your appointment without 24-hour notice may result in a fee of \$50 that will be charged directly to you as the patient (not insurance) for each instance of a missed appointment.

Signature of patient/authorized representative

Date

Printed name

Relationship to patient

Patient name:	DOB:
MEDICARE SECONDARY PAYER (MSP) FORM	
Part I	
1. Are you receiving benefits under the Black Lung Program? If yes, date benefits began: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Was this injury/illness due to a work-related accident/condition? If yes, date of injury/illness: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Was the injury/illness covered under no-fault (and/or medical-payment coverage) including premises or automobile? If yes, date of accident: _____ Is no-fault insurance available?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
4. Was this injury/illness related to an accident in which you intend to file liability suit or litigation pending? If yes, please provide: <u>Attorney's Name:</u> _____ <u>Address:</u> _____ <u>Phone Number:</u> _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
If you answered NO to all questions, go to Part II.	
If you answered YES to any of the questions above, Medicare is the secondary payer, you do not need to go to Part II. Please provide primary insurance information.	
Part II	
1. Are you entitled to Medicare based on? <i>Check the box that applies</i> <input type="checkbox"/> Age (65 & older) – go to question #2 <input type="checkbox"/> Disability – go to question #2 <input type="checkbox"/> End Stage – Go to Part III	
2. Do you have group health plan (GHP) coverage based on your own current employment, or the current employment of either your spouse or another family member? If yes, based upon if you are 65 & over or disabled, how many employees, including yourself or spouse, work for the employer from whom you have GHP coverage: <input type="checkbox"/> Aged (65 & over) - If you are aged and there are 20 or more employees, <u>your GHP is primary.</u> <input type="checkbox"/> Disability - If you are disabled and your employer, spouse, or family members employer, has 100 or more employees, <u>your GHP is primary.</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Part III	
<i>Medicare benefits are secondary to benefits payable under a GHP for individuals eligible for or entitled to benefits on the basis of ESRD during a period of up to 30-month period if Medicare was not the proper primary payer for the individual on the basis of age or disability at the time that this individual became eligible or entitled to Medicare on the basis of ESRD.</i>	
1. Do you have group health plan coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Are you within the 30-month coordination period?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes to BOTH questions, GHP is primary during the 30-month coordination period.	
Please provide a copy of your group health insurance if determined to be primary.	
Signature of Patient/Representative:	Date:
Relationship to Patient:	

Patient name:	DOB:
MALE PELVIC FLOOR HEALTH QUESTIONNAIRE	
Conditions related to the pelvic floor muscles can affect bladder, bowel, sexual, and physical function. Please answer the questions below so that we can better understand your problem. Please check all that apply.	
Occupation:	Height: Weight: Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Leisure Activities/Hobbies:	
Are you? <input type="checkbox"/> Right-handed <input type="checkbox"/> Left-handed	
Where do you live? <input type="checkbox"/> Private Home <input type="checkbox"/> Apartment/Rented Room <input type="checkbox"/> Assisted Living/Group Home <input type="checkbox"/> Hospice <input type="checkbox"/> Other:	
With whom do you live? <input type="checkbox"/> Alone <input type="checkbox"/> Spouse Only <input type="checkbox"/> Spouse and Others <input type="checkbox"/> Child <input type="checkbox"/> Other:	
Does your home have? <input type="checkbox"/> Stairs, No Railing <input type="checkbox"/> Stairs, Railing <input type="checkbox"/> Ramps <input type="checkbox"/> Uneven Terrain Please Explain:	
How many times have you fallen in the past 12 months?	Did it result in an injury? <input type="checkbox"/> Yes <input type="checkbox"/> No
During the past month have you been feeling down, depressed, or hopeless or bothered by having little interest or pleasure in doing things? <input type="checkbox"/> Yes <input type="checkbox"/> No	
General Health Status: Please rate your health. <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	
Please list any known allergies (including medications, latex, etc.) below.	

Surgery / Hospitalization, please include date and reason.	

Current Condition
Reason for today's visit?
How long have you had this problem?
Is it related to an injury or accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain how and when:
Since the problem began, has the problem become: <input type="checkbox"/> Worse <input type="checkbox"/> Better <input type="checkbox"/> Unchanged
Have you had therapy for the current or other problem in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, indicate type (physical therapy, speech therapy, etc.) and date
Have you received X-rays, MRI, CT scan, Bone scan for this problem? If so, please list the dates and results.
Are you aware of any physical reason why you should not receive treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please tell us what it is:
What are your goals for therapy?

Previous Tests for your condition:			
<input type="checkbox"/> Urodynamics study	<input type="checkbox"/> Video defecography	<input type="checkbox"/> X-ray	<input type="checkbox"/> Digital rectal exam
<input type="checkbox"/> Bladder scan (PVR)	<input type="checkbox"/> Colonoscopy	<input type="checkbox"/> CT scan	<input type="checkbox"/> Prostate biopsy
<input type="checkbox"/> Cystoscopy	<input type="checkbox"/> Anal manometry	<input type="checkbox"/> MRI	<input type="checkbox"/> Exploratory surgery

Patient Name:		DOB:
Other Medical		
<input type="checkbox"/> High blood pressure <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Sciatica <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Cigarette smoker <input type="checkbox"/> Acid reflux <input type="checkbox"/> Stenosis <input type="checkbox"/> High cholesterol <input type="checkbox"/> Former smoker <input type="checkbox"/> Depression <input type="checkbox"/> Arthritis – area _____ <input type="checkbox"/> Heart disease <input type="checkbox"/> Migraine headaches <input type="checkbox"/> Anxiety disorder <input type="checkbox"/> Bronchitis <input type="checkbox"/> Bone fracture – area _____	<input type="checkbox"/> Cardiac arrhythmia <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Hearing loss <input type="checkbox"/> Alzheimer's <input type="checkbox"/> Heart attack <input type="checkbox"/> Stroke <input type="checkbox"/> Glaucoma <input type="checkbox"/> Herniated disc <input type="checkbox"/> Angina <input type="checkbox"/> TIA (mini strokes) <input type="checkbox"/> Cataracts <input type="checkbox"/> Congestive heart failure <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Glasses <input type="checkbox"/> Degenerative disc – area _____ <input type="checkbox"/> Pacemaker	<input type="checkbox"/> Seizures <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Vascular disease <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Swollen legs/edema <input type="checkbox"/> Dementia <input type="checkbox"/> Osteopenia <input type="checkbox"/> Cancer – area _____ <input type="checkbox"/> Emphysema <input type="checkbox"/> Kidney stones <input type="checkbox"/> Low back pain <input type="checkbox"/> Sleep apnea <input type="checkbox"/> Tailbone trauma <input type="checkbox"/> Other _____

Review of Systems – Please check if you have recently had any of these symptoms.		
<input type="checkbox"/> Fever/chills <input type="checkbox"/> Weight change <input type="checkbox"/> Fatigue/night sweats <input type="checkbox"/> Skin rash/itch <input type="checkbox"/> Headaches <input type="checkbox"/> Hearing loss <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Ear pain/discharge <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Sore throat <input type="checkbox"/> Blurred vision <input type="checkbox"/> Double vision <input type="checkbox"/> Light sensitive <input type="checkbox"/> Eye pain/redness <input type="checkbox"/> Chest pain <input type="checkbox"/> Pounding heart <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Calf pain	<input type="checkbox"/> Leg swelling <input type="checkbox"/> Cough <input type="checkbox"/> Coughing up blood <input type="checkbox"/> Phlegm production <input type="checkbox"/> Congestion <input type="checkbox"/> Wheezing <input type="checkbox"/> Heartburn <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Stomach pain <input type="checkbox"/> Bloody stools <input type="checkbox"/> Tarry stools <input type="checkbox"/> Blood in urine <input type="checkbox"/> Muscle pain <input type="checkbox"/> Neck/back pain <input type="checkbox"/> Joint pain <input type="checkbox"/> Falls <input type="checkbox"/> Arm/leg weakness	<input type="checkbox"/> Lack of coordination <input type="checkbox"/> Difficulty walking <input type="checkbox"/> Difficulty standing up <input type="checkbox"/> Tingling/numbness <input type="checkbox"/> Tremors <input type="checkbox"/> Speech changes <input type="checkbox"/> Seizures <input type="checkbox"/> Loss of consciousness <input type="checkbox"/> Vertigo/spinning <input type="checkbox"/> Unsteadiness <input type="checkbox"/> Lightheaded <input type="checkbox"/> Depression <input type="checkbox"/> Nervous/anxious <input type="checkbox"/> Suicidal thoughts <input type="checkbox"/> Hallucinations <input type="checkbox"/> Substance abuse <input type="checkbox"/> Memory loss
Is your doctor aware of these recent symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Patient Name: _____ **DOB:** _____

Please answer the questions below. If your symptom severity fluctuates, characterize your symptoms at their worst.

Bladder Health

Do you have a urologist? Yes No If yes, who? _____

During the **daytime**, how often do you urinate? Every 30-60 minutes 1-2 hours 2-3 hours 3-4 hours
 More than 4 hours

During the **nighttime** (after you've fallen asleep), how often do you get up to urinate? 0-1 times per night
 2-3 times 3-4 times More than 4 times

How many 8-ounce servings (cups) do you drink of the following?

Coffee (Reg. Decaf) _____ Per day _____ Per week On occasion Never

Tea (Reg. Decaf) _____ Per day _____ Per week On occasion Never

Soda (Reg. Diet) _____ Per day _____ Per week On occasion Never

Beer/Wine/Liquor _____ Per day _____ Per week On occasion Never

Water _____ Per day _____ Per week On occasion Never

Juice _____ Per day _____ Per week On occasion Never

Other: _____ Per day _____ Per week On occasion Never

Do you ever lose urine (even a few drops) with any of the situations below?

	Never	On occasion	Sometimes	Usually	Always
Cough					
Sneeze					
Laugh					
Getting out of a chair					
Getting out of a car					
Getting out of bed at night or morning					
Picking objects off the floor					
Putting on shoes or clothes					
Lifting light items					
Lifting heavy items					
Cooking or doing dishes					
Doing housework					
Doing yard work					
During sexual activity					
Walking to the toilet at home					
Shopping or running errands					
Standing or walking for a long time					
Walking to toilet in public					
Recreational activities					
Exercise activities					
Other _____					

Do you ever have strong or difficult-to-control urges to urinate with the situations listed below?

	Never	On occasion	Sometimes	Usually	Always
Around running water					
Feeling cold					
Feeling anxious or nervous					
Unlocking the door					
If I've waited too long					
Rushing off to the toilet					

Patient Name:	DOB:
How long can you usually delay an urge to urinate? <input type="checkbox"/> I rarely feel urges to void <input type="checkbox"/> I go as soon as I feel an urge <input type="checkbox"/> 1-2 minutes <input type="checkbox"/> Several minutes <input type="checkbox"/> 10-15 minutes <input type="checkbox"/> 15 minutes or more	
What type of protective padding do you use for bladder control? <input type="checkbox"/> None needed <input type="checkbox"/> Change underwear <input type="checkbox"/> Folded tissue paper <input type="checkbox"/> Liners <input type="checkbox"/> Thin pads <input type="checkbox"/> Thick pads <input type="checkbox"/> Diapers <input type="checkbox"/> Other	
How often do you change your bladder protection? <input type="checkbox"/> None <input type="checkbox"/> Only when I leave the house <input type="checkbox"/> Only at night <input type="checkbox"/> Only during a cold <input type="checkbox"/> Only during exercise <input type="checkbox"/> 1-2 per day <input type="checkbox"/> 3-4 per day <input type="checkbox"/> 4+ per day	
How saturated does your protection get? <input type="checkbox"/> No leakage <input type="checkbox"/> "Near misses" <input type="checkbox"/> A few drops <input type="checkbox"/> Damp <input type="checkbox"/> Wet <input type="checkbox"/> Soaked <input type="checkbox"/> Overflows onto clothes	
How often do you go to the bathroom before you feel urges to void, "just in case?" <input type="checkbox"/> Never <input type="checkbox"/> On occasion <input type="checkbox"/> Sometimes <input type="checkbox"/> Usually <input type="checkbox"/> Always	
How often do you avoid drinking fluid in order to help with bladder control? <input type="checkbox"/> Never <input type="checkbox"/> On occasion <input type="checkbox"/> Sometimes <input type="checkbox"/> Usually <input type="checkbox"/> Always	

Do you ever notice any of the following bladder symptoms? Please check how often.					
	Never	On occasion	Sometimes	Usually	Always
Weak stream					
Incomplete bladder emptying					
Trouble starting urine stream					
Strain to urinate					
Dribble after urinating					
Have to rock pelvis to empty bladder					
Have to push over the bladder to empty					
Splint or support bladder to urinate					
Pain as my bladder <i>fills</i>					
Location:	<input type="checkbox"/> Bladder <input type="checkbox"/> Urethra <input type="checkbox"/> Abdomen				
Circle severity:	No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain				
Pain as my bladder <i>empties</i>					
Location:	<input type="checkbox"/> Bladder <input type="checkbox"/> Urethra <input type="checkbox"/> Abdomen				
Circle severity:	No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain				

Bowel Health
Do you have a gastroenterologist? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, who?
How often do you have a bowel movement? <input type="checkbox"/> Less than 3 times a week <input type="checkbox"/> Every 2-3 days <input type="checkbox"/> Every 1-2 days <input type="checkbox"/> Daily <input type="checkbox"/> 2-3 times per day <input type="checkbox"/> More than 3 times per day <input type="checkbox"/> I won't go for several days, and then go multiple times in one day
What is the consistency of your bowel movements? <input type="checkbox"/> Watery/formless <input type="checkbox"/> Loose and thin <input type="checkbox"/> Soft and formed <input type="checkbox"/> Hard and rocky <input type="checkbox"/> Small and pellet-like <input type="checkbox"/> It varies:

Do you ever lose feces with any of the situations below? Please check how often.					
	Never	On occasion	Sometimes	Usually	Always
On the way to the toilet					
If I exert myself					
When I pass gas					
I have fecal soiling without an urge to have a BM					

What type of protective padding do you use for bowel control? <input type="checkbox"/> None needed <input type="checkbox"/> Change underwear <input type="checkbox"/> Folded tissue paper <input type="checkbox"/> Liners <input type="checkbox"/> Thin pads <input type="checkbox"/> Thick pads <input type="checkbox"/> Diapers <input type="checkbox"/> Other
How often do you change your bowel protection? <input type="checkbox"/> None <input type="checkbox"/> Only when I leave the house <input type="checkbox"/> Only when I have diarrhea/ loose stools <input type="checkbox"/> 1-2 per day <input type="checkbox"/> 3-4 per day <input type="checkbox"/> 4+ per day

Patient Name:		DOB:			
Do you ever notice any of the following bowel symptoms? Please check how often.					
	Never	On occasion	Sometimes	Usually	Always
Excessive straining during a BM					
Support/splint rectum during BM					
Incomplete BM's					
Rush to the toilet with BM urge					
Trouble controlling gas in public					
Excessive wiping needed after BM					
Fecal soiling in underwear after BM					
Pain as my bowels <i>fill</i>					
Location:	<input type="checkbox"/> Rectum <input type="checkbox"/> Abdomen				
Circle severity:	No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain				
Pain as my bowels <i>empty</i>					
Location:	<input type="checkbox"/> Rectum <input type="checkbox"/> Abdomen				
Circle severity:	No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain				

Pelvic Pain Symptoms			
<input type="checkbox"/> None			
My pelvic symptoms affect my ability to, OR I feel worse when I try to: Check all that apply.			
<input type="checkbox"/> Sleep <input type="checkbox"/> Bathe <input type="checkbox"/> Get dressed <input type="checkbox"/> Wear tight clothing <input type="checkbox"/> Cook meals <input type="checkbox"/> Do housework <input type="checkbox"/> Get out of a car	<input type="checkbox"/> Bend forward <input type="checkbox"/> Squat down <input type="checkbox"/> Lift items <input type="checkbox"/> Reach overhead <input type="checkbox"/> Get out of bed <input type="checkbox"/> Stand up from a chair	<input type="checkbox"/> Climb stairs <input type="checkbox"/> Sitting tolerance <input type="checkbox"/> Standing tolerance <input type="checkbox"/> Walking distance <input type="checkbox"/> Drive a car <input type="checkbox"/> Perform work duties	<input type="checkbox"/> Recreational activities <input type="checkbox"/> Social events <input type="checkbox"/> Travel <input type="checkbox"/> Do yard work <input type="checkbox"/> Do Kegel exercises
Pain Location: Check all that apply.			
<input type="checkbox"/> Abdomen <input type="checkbox"/> Scrotum <input type="checkbox"/> Inner thighs <input type="checkbox"/> Side/waist <input type="checkbox"/> Over tight surgical scars <input type="checkbox"/> Penis	<input type="checkbox"/> Urethra <input type="checkbox"/> Bladder <input type="checkbox"/> Tailbone <input type="checkbox"/> Rectum <input type="checkbox"/> Low back <input type="checkbox"/> Urethra	<input type="checkbox"/> Buttocks <input type="checkbox"/> Groin <input type="checkbox"/> Sides of hips <input type="checkbox"/> Back of hips <input type="checkbox"/> Front of hips	
Circle pain severity: No Pain 0__1__2__3__4__5__6__7__8__9__10 Worst Pain			
Pain with sexual activity:			
<input type="checkbox"/> None			
<input type="checkbox"/> I have to interrupt intercourse due to pain.			
<input type="checkbox"/> I limit the frequency of sexual activity because of my pain.			
<input type="checkbox"/> I avoid it altogether due to my pain. Last intercourse attempt: _____			
The pain occurs during: <input type="checkbox"/> Erection <input type="checkbox"/> Ejaculation			
For how long? <input type="checkbox"/> Only during sexual activity <input type="checkbox"/> For a few hours afterwards <input type="checkbox"/> For a day or more afterwards			
Location of pain: <input type="checkbox"/> Penis/scrotum <input type="checkbox"/> Deep in my pelvis <input type="checkbox"/> In my back			
Circle pain severity: No pain 0__1__2__3__4__5__6__7__8__9__10 Worst Pain			

Patient/Guardian Signature _____

Date _____

INFORMED CONSENT FOR PELVIC FLOOR MUSCLE EVALUATION AND TREATMENT

Patient Name: _____ DOB: _____

The term, "informed consent," means that the potential risks, benefits, and alternatives of therapy evaluation and treatment have been explained to me. 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 understand I have been referred to therapy for evaluation and treatment of pelvic floor dysfunction. Pelvic floor dysfunctions include 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.

As part of your evaluation and treatment for pelvic floor dysfunction, your therapist may initially and periodically perform an internal assessment of the pelvic floor muscles, assessing muscle tone, length, strength and endurance, scar mobility and function of the pelvic floor region. This examination is performed by observing and/or palpating the perineal region including the vagina and/or rectum. The findings will be discussed with you, and you will collaborate with your therapist to develop a treatment plan that is appropriate for you. Please discuss any concerns or hesitations that you may have with your therapist.

Treatment procedures for pelvic floor dysfunctions may include, without limitation, education, exercise, stimulation, ultrasound, and manual therapy techniques including massage, joint and soft tissue mobilization. The therapist will explain all the treatment procedures prior to performing, and you may choose not to participate in all or part of the treatment.

I understand that the benefits of the vaginal/rectal assessment have been explained to me. I understand that if I am uncomfortable with the assessment or treatment procedures AT ANY TIME, I will inform my therapist, and the procedure will be discontinued, and an alternative discussed with me.

I understand that no guarantees have been or can be provided to me regarding the success of therapy.

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

You have the option to have a second person in the room for the pelvic floor muscle evaluation and treatment. 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.

By signing this form, I understand that treatment as indicated above may be necessary for effective treatment of my condition and all my questions have been answered to my satisfaction. I understand the risk, benefits, and alternative of the treatment.

I have read and understand the Informed Consent for Pelvic Floor Muscle Evaluation and Treatment, and I consent to the evaluation and treatment.



**If you are pregnant, have an infection of any kind, have vaginal dryness, are less than 6 weeks post-partum or post-surgery, have severe pelvic pain, sensitivity to creams, please inform the therapist prior to pelvic floor assessment.*

Patient Signature (if over 18) _____ **Date:** _____

Patient/Guardian Signature **Date**

Printed name **Relationship to patient**