

Patient Registration Form – Female Pelvic Health

Patient Name:		Preferred:	
Address, City, State, Zip:			
DOB:		Social Security #:	
Email Address:			
Home Phone:		Appointment Reminder Method	
Cell Phone:		☐ Home Phone	☐ Cell Phone
Work Phone:		☐ Work Phone	☐ Email
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed		Partner's Name:	
Financial Responsibility: ☐ Self ☐ 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? ☐ Yes ☐ No If yes, # of Visits:			
Have you had Chiropractic treatment since January of this year? ☐ Yes ☐ No If yes, # of Visits:			
Have you had Home Healthcare in the last 30 days? ☐ Yes ☐ 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

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.

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.

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.

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.

Signature of Patient/Guardian

Date

Print Name and 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:

Patient name:	DOB:
Financial Policy	
<u>Payment for services is due at the time services are rendered</u> 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:

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.
Patient/Guardian Signature:
Date:

Patient name:		DOB:	
FEMALE 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: ☐ Male ☐ Female
Leisure Activities/Hobbies:			
Are you? ☐ Right-handed ☐ Left-handed			
Where do you live? ☐ Private Home ☐ Apartment/Rented Room ☐ Assisted Living/Group Home ☐ Hospice ☐ Other:			
With whom do you live? ☐ Alone ☐ Spouse Only ☐ Spouse and Others ☐ Child ☐ Other:			
Does your home have? ☐ Stairs, No Railing ☐ Stairs, Railing ☐ Ramps ☐ Uneven Terrain Please Explain:			
How many times have you fallen in the past 12 months?		Did it result in an injury? ☐ Yes ☐ No	
During the past month have you been feeling down, depressed, or hopeless or bothered by having little interest or pleasure in doing things? ☐ Yes ☐ No			
General Health Status: Please rate your health. ☐ Excellent ☐ Good ☐ Fair ☐ 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? ☐ Yes ☐ No If yes, explain how and when:
Since the problem began, has the problem became: ☐ Worse ☐ Better ☐ Unchanged
Have you had therapy for the current or other problem in the past year? ☐ Yes ☐ 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? ☐ Yes ☐ No If yes, please tell us what it is:
What are your goals for therapy?

Previous Tests for your condition:			
☐ Urodynamics study ☐ Bladder scan (PVR) ☐ Cystoscopy ☐ Hysteroscopy	☐ Video defecography ☐ Colonoscopy ☐ Anal manometry	☐ X-ray ☐ CT scan ☐ MRI	☐ Potassium test ☐ Exploratory surgery



Patient Name:		DOB:	
Previous Treatments for your condition			
☐ Kegel exercises ☐ Biofeedback ☐ Pelvic floor rehab ☐ Diet/fluid changes ☐ Pessary ☐ Bladder surgery ☐ Bladder control meds ☐ Collagen injections ☐ InterStim ☐ Self-catheterization ☐ BCG ☐ Bladder instillations	☐ Rectocele repair ☐ Hemorrhoid repair ☐ Radiation ☐ Ostomy pouch ☐ Hemorrhoid cream ☐ High fiber diet ☐ Probiotics ☐ Stool softeners ☐ Anti-diarrheal meds ☐ Herbal supplements ☐ Nerve injections/blocks	☐ Tubal ligation ☐ Infertility treatments ☐ Removal of endometria ☐ Removal of adhesions ☐ Hysterectomy ☐ Abdominal ☐ Vaginal ☐ With bladder repair ☐ One ovary removed ☐ Both ovaries removed Reason/Age -	☐ Massage therapy ☐ Chiropractor ☐ Acupuncture ☐ Vaginal dilators ☐ Over the counter pain meds ☐ Prescription pain meds ☐ Urethral/bladder dilation ☐ Other _____

Bladder			
☐ Urinary incontinence ☐ Overactive bladder ☐ Urinary retention ☐ Small bladder capacity ☐ Large bladder capacity ☐ Fallen bladder (cystocele)	☐ Bladder cancer ☐ Interstitial cystitis ☐ Other _____ ☐ Bladder infections (UTI's) ☐ Painful bladder syndrome		
Bowels			
☐ Fecal incontinence ☐ Constipation ☐ Diarrhea ☐ Irritable bowel synd. ☐ Ulcerative colitis ☐ Spastic colon ☐ Diverticulitis ☐ Diverticulosis	☐ Hemorrhoids ☐ Lactose intolerance ☐ Gluten intolerance ☐ Other _____ ☐ Colon cancer ☐ Anal cancer ☐ Colostomy/ileostomy		
Obstetrical			
_____ Number of pregnancies _____ Number of vaginal deliveries _____ Number of C-Section deliveries _____ Weight of largest baby I'm pregnant now; due date _____	Other complications _____ ☐ Vaginal tear ☐ Episiotomy ☐ Vaginal stitches ☐ Use of forceps or suction		
Gynecological			
☐ Endometriosis ☐ Pudendal neuralgia ☐ Ovarian cysts ☐ Bladder (cystocele) ☐ Vulvodynia ☐ Uterine fibroids ☐ Vaginismus ☐ Yeast infections ☐ Uterine prolapse	☐ Cervical cancer ☐ Rectum (rectocele) ☐ Bulge in the vagina ☐ Ovarian cancer ☐ "Falling out" feeling ☐ Uterine cancer ☐ Yeast infections ☐ Other _____	Menstruation Status ☐ Normal periods ☐ Irregular periods ☐ Painful periods ☐ Peri-menopausal ☐ Post-menopausal ☐ Hysterectomy	Use of Hormones ☐ None Used ☐ Birth control pills ☐ Estrogen replacement ☐ Oral medication ☐ Skin patch ☐ Vaginal cream ☐ Suppository
Sexual Function: ☐ I'm sexually active ☐ I'm not sexually active due to: ☐ My pelvic pain symptoms ☐ For non-health related reasons ☐ My other medical problems ☐ My partner's medical problems			

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

Review of Systems – Please check if you have recently had any of these symptoms.		
☐ Fever/chills ☐ Weight change ☐ Fatigue/night sweats ☐ Skin rash/itch ☐ Headaches ☐ Hearing loss ☐ Ringing in ears ☐ Ear pain/discharge ☐ Nose bleeds ☐ Sore throat ☐ Blurred vision ☐ Double vision ☐ Light sensitive ☐ Eye pain/redness ☐ Chest pain ☐ Pounding heart ☐ Shortness of breath ☐ Calf pain	☐ Leg swelling ☐ Cough ☐ Coughing up blood ☐ Phlegm production ☐ Congestion ☐ Wheezing ☐ Heartburn ☐ Nausea/vomiting ☐ Stomach pain ☐ Bloody stools ☐ Tarry stools ☐ Blood in urine ☐ Muscle pain ☐ Neck/back pain ☐ Joint pain ☐ Falls ☐ Arm/leg weakness	☐ Lack of coordination ☐ Difficulty walking ☐ Difficulty standing up ☐ Tingling/numbness ☐ Tremors ☐ Speech changes ☐ Seizures ☐ Loss of consciousness ☐ Vertigo/spinning ☐ Unsteadiness ☐ Lightheaded ☐ Depression ☐ Nervous/anxious ☐ Suicidal thoughts ☐ Hallucinations ☐ Substance abuse ☐ Memory loss
Is your doctor aware of these recent symptoms? ☐ Yes ☐ 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? ☐ I rarely feel urges to void ☐ I go as soon as I feel an urge ☐ 1-2 minutes ☐ Several minutes ☐ 10-15 minutes ☐ 15 minutes or more	
What type of protective padding do you use for bladder control? ☐ None needed ☐ Change underwear ☐ Folded tissue paper ☐ Liners ☐ Thin pads ☐ Thick pads ☐ Diapers ☐ Other	
How often do you change your bladder protection? ☐ None ☐ Only when I leave the house ☐ Only at night ☐ Only during a cold ☐ Only during exercise ☐ 1-2 per day ☐ 3-4 per day ☐ 4+ per day	
How saturated does your protection get? ☐ No leakage ☐ "Near misses" ☐ A few drops ☐ Damp ☐ Wet ☐ Soaked ☐ Overflows onto clothes	
How often do you go to the bathroom before you feel urges to void, "just in case?" ☐ Never ☐ On occasion ☐ Sometimes ☐ Usually ☐ Always	
How often do you avoid drinking fluid in order to help with bladder control? ☐ Never ☐ On occasion ☐ Sometimes ☐ Usually ☐ 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:	☐ Bladder ☐ Urethra ☐ 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:	☐ Bladder ☐ Urethra ☐ 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? ☐ Yes ☐ No If yes, who?
How often do you have a bowel movement? ☐ Less than 3 times a week ☐ Every 2-3 days ☐ Every 1-2 days ☐ Daily ☐ 2-3 times per day ☐ More than 3 times per day ☐ I won't go for several days, and then go multiple times in one day
What is the consistency of your bowel movements? ☐ Watery/formless ☐ Loose and thin ☐ Soft and formed ☐ Hard and rocky ☐ Small and pellet-like ☐ 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? ☐ None needed ☐ Change underwear ☐ Folded tissue paper ☐ Liners ☐ Thin pads ☐ Thick pads ☐ Diapers ☐ Other
How often do you change your bowel protection? ☐ None ☐ Only when I leave the house ☐ Only when I have diarrhea/ loose stools ☐ 1-2 per day ☐ 3-4 per day ☐ 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:	☐ Rectum ☐ 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:	☐ Rectum ☐ Abdomen				
Circle severity:	No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain				

GYN Health			
Do you have an OB/GYN? ☐ Yes ☐ No If yes, who?			
Vulvar symptoms: ☐ Dryness ☐ Itching ☐ Discharge ☐ Numbness/tingling ☐ Redness ☐ Swelling ☐ None			
Pelvic pain symptoms: ☐ None			
My pelvic symptoms affect my ability to, OR I feel worse when I try to: Check all that apply.			
☐ Sleep ☐ Bathe ☐ Get dressed ☐ Wear tight clothing ☐ Wear a tampon ☐ Cook meals ☐ Do housework	☐ Bend forward ☐ Squat down ☐ Lift items ☐ Reach overhead ☐ Get out of bed ☐ Stand up from a chair ☐ Get out of a car	☐ Climb stairs ☐ Sitting tolerance ☐ Standing tolerance ☐ Walking distance ☐ Drive a car ☐ Run errands/shop ☐ Perform work duties	☐ Recreational activities ☐ Social events ☐ Travel ☐ Do yard work ☐ Have a GYN exam ☐ Do Kegel exercises
Pain Location: Check all that apply.			
☐ Abdomen ☐ Inner thighs ☐ Side/waist ☐ Over tight surgical scars ☐ Vagina ☐ Clitoris	☐ Urethra ☐ Bladder ☐ Tailbone ☐ Rectum ☐ Low back	☐ Buttocks ☐ Groin ☐ Sides of hips ☐ Back of hips ☐ 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:			
☐ None ☐ I have to interrupt intercourse due to pain. ☐ I limit the frequency of sexual activity because of my pain. ☐ I avoid it altogether due to my pain. Last intercourse attempt: _____			
The pain occurs during: ☐ Vulvar touching ☐ Vaginal penetration ☐ Thrusting ☐ Orgasm			
For how long? ☐ Only during sexual activity ☐ For a few hours afterwards ☐ For a day or more afterwards			
Location of pain: ☐ Vaginal opening ☐ Clitoris ☐ Deep in my pelvis ☐ In my back			
Circle pain severity: No pain 0__1__2__3__4__5__6__7__8__9__10 Worst Pain			

*** 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/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/Guardian Signature

Date

Printed name

Relationship to patient