LAKE CENTRE for REHAB

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:	☐ 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 Relationship to the Patient

LAKE CENTRE for REHAB

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

☐ **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:

LAKE CENTRE for REHAB

Patient name:	**DOB:**

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:

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:

LAKE CENTRE for REHAB

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: _____	☐ Yes	☐ No
2. Was this injury/illness due to a work-related accident/condition? If yes, date of injury/illness: _____	☐ Yes	☐ 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?	☐ Yes ☐ Yes	☐ No ☐ 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: Attorney's Name: _____ Address: _____ Phone Number: _____ 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.	☐ Yes	☐ No
Part II		
1. Are you entitled to Medicare based on? *Check the box that applies* ☐ Age (65 & older) – go to question #2 ☐ Disability – go to question #2 ☐ 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: ☐ Aged (65 & over) - If you are aged and there are 20 or more employees, <u>your GHP is primary.</u> ☐ Disability - If you are disabled and your employer, spouse, or family members employer, has 100 or more employees, <u>your GHP is primary</u>.	☐ Yes ☐ Yes ☐ Yes	☐ No ☐ No ☐ No
Part III		
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.		
1. Do you have group health plan coverage?	☐ Yes	☐ No
2. Are you within the 30-month coordination period?	☐ Yes	☐ 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:		

LAKE CENTRE for REHAB

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: ☐ 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	☐ Video defecography	☐ X-ray	☐ Digital rectal exam
☐ Bladder scan (PVR)	☐ Colonoscopy	☐ CT scan	☐ Prostate biopsy
☐ Cystoscopy	☐ Anal manometry	☐ MRI	☐ Exploratory surgery

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Patient Name:			**DOB:**
Previous Treatments for your condition			
☐ Prostatectomy	☐ Pelvic floor rehab	☐ Hemorrhoid cream	☐ Chiropractor
☐ Radiation	☐ Diet/fluid changes	☐ Infertility treatments	☐ Acupuncture
☐ Seed implantation	☐ Ostomy pouch	☐ High fiber diet	☐ Over the counter pain meds
☐ Cryotherapy	☐ Bladder control meds	☐ Probiotics	☐ Prescription pain meds
☐ Proton therapy	☐ Collagen injections	☐ Stool softeners	☐ Urethral/bladder dilation
☐ Lupron/hormones	☐ Self-catheterization	☐ Constipation meds	☐ Nerve injections/blocks
☐ Greenlight ablation	☐ InterStim	☐ Anti-diarrheal meds	☐ Other _____
☐ TURP	☐ Artificial sphincter	☐ Herbal supplements	
☐ BCG treatments	☐ Penile clamp	☐ Enemas	
☐ Condom catheter	☐ Kegel exercises	☐ Bladder instillations	
☐ Biofeedback	☐ Hemorrhoid repair	☐ Massage therapy	

Prostate

☐ Enlarged prostate (BPH) ☐ Prostate infections ☐ Chronic prostatitis ☐ Prostate pain
☐ Erectile dysfunction ☐ Erectile/ejaculation pain
☐ Prostate cancer: If so, when were you diagnosed? _____ What was your Gleason score? _____
☐ Last PSA reading: _____

Sexual Function:

☐ I'm sexually active ☐ I'm not sexually active due to:
☐ My pelvic pain symptoms ☐ *My other* medical problems
☐ For non-health related reasons ☐ *My partner's* medical problems

Bladder

☐ Urinary incontinence	☐ Bladder cancer
☐ Overactive bladder	☐ Interstitial cystitis
☐ Urinary retention	☐ Other _____
☐ Small bladder capacity	☐ Bladder infections (UTI's)
☐ Large bladder capacity	☐ Painful bladder syndrome
☐ Kidney stones	

Bowels

☐ Fecal incontinence	☐ Hemorrhoids
☐ Constipation	☐ Lactose intolerance
☐ Diarrhea	☐ Gluten intolerance
☐ Irritable bowel synd.	☐ Other _____
☐ Ulcerative colitis	☐ Colon cancer
☐ Spastic colon	☐ Anal cancer
☐ Diverticulitis	☐ Colostomy/ileostomy
☐ Diverticulosis	

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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		

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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					

LAKE CENTRE for REHAB

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 *fills*					
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 *empties*					
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

LAKE CENTRE for REHAB

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 *fill*					
Location:	☐ Rectum ☐ Abdomen				
Circle severity:	No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain				
Pain as my bowels *empty*					
Location:	☐ Rectum ☐ Abdomen				
Circle severity:	No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain				

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 ☐ Cook meals ☐ Do housework ☐ Get out of a car	☐ Bend forward ☐ Squat down ☐ Lift items ☐ Reach overhead ☐ Get out of bed ☐ Stand up from a chair	☐ Climb stairs ☐ Sitting tolerance ☐ Standing tolerance ☐ Walking distance ☐ Drive a car ☐ Perform work duties	☐ Recreational activities ☐ Social events ☐ Travel ☐ Do yard work ☐ Do Kegel exercises

Pain Location: Check all that apply.

☐ Abdomen ☐ Scrotum ☐ Inner thighs ☐ Side/waist ☐ Over tight surgical scars ☐ Penis	☐ Urethra ☐ Bladder ☐ Tailbone ☐ Rectum ☐ Low back ☐ Urethra	☐ 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: ☐ Erection ☐ Ejaculation

For how long? ☐ Only during sexual activity ☐ For a few hours afterwards ☐ For a day or more afterwards

Location of pain: ☐ Penis/scrotum ☐ 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

_____ _____

Patient/Guardian Signature Date

LAKE CENTRE for REHAB

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 perinea l 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**