Pelvic Floor Therapy

INTAKE FORM

PATIENT INFORMATION

Full Name: _____ Today's Date: ____/____/____

Preferred Name/Nickname: _____ Date of Birth: ____/____/____ Gender: _____

Address: _____

City: _____ Zip/Postal Code: _____

Email Address: _____ Cell Phone Number: _____

Cell Phone Provider: _____ OK to recieve texts? ☐ Yes ☐ No

Occupation: _____ Employer: _____

Marital Status: _____ Spouse's Name (if applicable): _____

EMERGENCY CONTACT INFORMATION

Name: _____ Phone Number: _____ Relation: _____

How did you hear about Live Zena?

☐ Google ☐ Instagram ☐ Facebook ☐ Event ☐ Primary Doctor ☐ OBYN

☐ Creekside Performance ☐ Other: _____

CONCERNS + TREATMENT GOALS

Briefly describe why you're seeking treatment: _____

_____

Date Symptoms Appeared: ____/____/____ **Have you had this issue in the past?** ☐ Yes ☐ No

Have you seen anyone else for this condition? ☐ Yes ☐ No **If yes, who/where?** _____

What treatments were performed? _____

Who is your OBGYN? _____

What are your goals for treatment? _____

_____

_____

PELVIC FLOOR MEDICAL HISTORY

Urinary Symptoms

☐ Yes ☐ No **Do you experience urinary leakage? If yes, for how long?** _____ months/years

Do you experience leaking during the following times? Check all that apply:

☐ Coughing/Sneezing/Laughing ☐ Walking/Running ☐ With Intercourse

☐ On The Way To The Bathroom ☐ Minimal Activity ☐ Laying Down

What amount of leakage do you experience?

☐ Drops ☐ More than Drops ☐ Flood

☐ Yes ☐ No **Do you use a pad for leakage?** **If yes, how many pads in a day?** _____

☐ Yes ☐ No **After emptying your bladder do you feel like you have completely finished?**

☐ Yes ☐ No **Do you find it hard to begin urinating?**

☐ Yes ☐ No **Any kidney infections (pyelonephritis)?**

☐ Yes ☐ No **Any history of kidney stones?**

How many times do you urinate during the day? _____

How many times do you urinate during the night after you go to sleep? _____

Number of urinary tract infections in the last year? _____

Bowel Symptoms

How often do you have a bowel movement? _____

☐ Yes ☐ No **Do you strain to have a bowel movement?**

☐ Yes ☐ No **After emptying your bladder do you feel like you have completely finished?**

☐ Yes ☐ No **Do you push with a finger in the vagina to assist with a bowel movement?**

☐ Yes ☐ No **Do you have any constipation?**

☐ Yes ☐ No **Do you use any laxitives?**

☐ Yes ☐ No **Do you have diarrhea/loose stools?**

☐ Yes ☐ No **Do you have fecal urgency and do not make it to the bathroom in time?**

☐ Yes ☐ No **Do you have fecal seepage or staining on your underwear?**

☐ Yes ☐ No **Do you usually lose stool beyond your control if your stool is loose?**

☐ Yes ☐ No **Do you have difficulty controlling formed stool?**

Prolapse Symptoms

☐ Yes ☐ No **Do you feel any vaginal or lower abdominal pressure?**

☐ Yes ☐ No **Do you see or feel a bulge or something falling out in the vaginal area?**

☐ Yes ☐ No **Do you see or feel a bulge or something falling out in the rectal area?**

Sexual Symptoms

☐ Yes ☐ No **Have you ever had sexual relations?**

☐ Yes ☐ No **If yes, do you have pain with sex?**

☐ Yes ☐ No **Are you currently having sexual relations?**

☐ Yes ☐ No **If yes, are you satisfied with your sex life?**

GENERAL MEDICAL HISTORY

Please list any current health conditions (i.e. hypertension, diabetes, hypothyroidism, etc.)

Please list all prior surgeries, procedures, and/or injections (include body area, procedure type, and date)

Please list any current medications, vitamins, or supplements (name, dosage, frequency, what it is taken for)

Please list any allergies (i.e. latex, seasonal, medications, etc.)

Are there any notable diseases in your family history? (i.e. hypertension, diabetes, stroke)
Please also list family member relationship for each disease (i.e. mother)

☐ Yes ☐ No **Do you use tobacco products?**
If so, what type? (cigarette, vape, etc.) and amount? _____

☐ Yes ☐ No **Do you consume alcohol?**
If so, how many drinks per week? _____

☐ Yes ☐ No **Do you exercise regularly?**
If so, what type of exercise & frequency? _____

☐ Yes ☐ No **Do you consider your diet healthy?**

PREGNANCY HISTORY

How many times have you ever been pregnant? _____ **Of these pregnancies, how many were:**

Full Term Deliveries: _____ Preterm Deliveries: _____

Miscarriages: _____ Abortions: _____

If applicable, of your pregnancies that resulted in delivery, how many were:

Vaginal Delivery: _____ Vaginal delivery with forceps assistance: _____

Cesarean: _____ Vaginal dellivery with vacuum assistance: _____

☐ Yes ☐ No **If applicable, for any vaginal deliveries, did you have any vaginal tearing?**

Degree of tear(s): _____

If applicable, what was/is the weight of your largest baby? _____

MENSTRUAL HISTORY

When was the first day of your last period? _____

How often do you have your period? _____

How long does your period last? _____

Have you ever had an abnormal pap test? _____

Have you ever had a pelvic infection? (i.e. gonorrhea, chlamydia, herpes) _____

When was your last Pap smear? _____

When was your last mammogram? _____

☐ Yes ☐ No ☐ Unsure **Have you gone through menopause?**

If you answered "No" above:

Are you using any contraception? _____

Have you completed your family? _____

If you answered "Yes" above:

After menopause, did you use hormone replacement therapy? ☐ Never ☐ Past ☐ Currently

After menopause, did you use vaginal hormone therapy? ☐ Never ☐ Past ☐ Currently

Additional notes you would like to share:

_____

_____

_____

INFORMED CONSENT TO PELVIC FLOOR EVALUATION AND TREATMENT

I hereby request and consent to pelvic floor therapy and other procedures including various modes of physiotherapies, and/or testing by Creekside Performance Center who now or in the future treat me while a patient at this office. I will discuss with my provider the nature and purpose of treatment indicated. I understand that results are not guaranteed and I am informed that there are some risks to treatment, including but not limited to: soreness and increased pain. I do not expect the provider to be able to anticipate and explain all risks and complications, and will rely on the provider to exercise judgment during the course of any procedure which the provider feels at the time is in my best interest. I have read, or have had read to me, the full above consent and have also had the opportunity to ask questions about its content and by signing below I agree to the above terms and procedures. I intend this consent to cover any treatment for my present condition and for any further conditions for which I seek treatment by this clinic and/or employed staff.

The term “informed consent” means that the potential risks, benefits, and alternatives of therapy evaluation and treatment have been explained. 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. Pelvic floor dysfunctions include, but are not limited to, urinary or fecal incontinence, difficulty with bowel or bladder functions, sacroiliac conditions, sexual dysfunction, and/or pelvic pain conditions.

I understand that to evaluate my condition it may be necessary, initially and periodically, to have my therapist perform an internal pelvic floor muscle examination. This examination is performed primarily by observing and/or palpating the perineal region, including the vagina and/or rectum externally and /or internally. This evaluation will assess skin condition, reflexes, muscle tone, length, strength and endurance, scar and nerve mobility and tenderness, as well as the function of the pelvic floor region.
I understand that the benefits of the vaginal/rectal assessment will be explained to me. I understand that if I am uncomfortable with the assessment or treatment procedures AT ANY TIME, I will inform my provider and the procedure will be discontinued and alternatives will be discussed with me.

Treatment may include, but is not limited to the following: observation, palpation, biofeedback and/or electrical stimulation, stretching and strengthening exercises, soft tissue and/or joint mobilization, relaxation techniques, use of vaginal weights and several manual techniques including massage, as well as educational instruction. Treatment may also include the use of vaginal dilators. The therapist will explain all these treatment procedures to me and I may choose to not participate with all or part of the treatment plan.

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

Potential benefits:
I may experience 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 a greater knowledge about managing my condition and the resources available to me.

Alternatives:
If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider.

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

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 exercise program assigned to me. If I have difficulty with any part of my treatment program, I will discuss it with my provider.

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

Based on the information I have received, I voluntarily consent to pelvic floor therapy evaluation and treatment. I understand that I may withdraw at any time.

Patient Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

OFFICE POLICIES

Cancellation Policy:

Our goal is to provide quality services to all our patients in a timely manner. When scheduling your pelvic floor therapy, we do require a credit card to be kept in our secure file. No-shows, late arrivals, and cancellations inconvenience not only our provider, but our other clients as well. Please be aware we do have a 24 hour cancellation policy. If you need to reschedule an appointment please allow at least 24 hours notice to avoid any fees. Cancellations within 24 hours will be charged half of the service price to the credit card on file. No call/no show missed appointments will result in full service price being charged.

Patient Initials: _____

HIPAA:

I acknowledge that I have, if requested, received a copy of The Notice of Privacy Practices for Protected Health Information, and I understand the authorizations listed.

Patient Initials: _____

Billing of Services:

I acknowledge that the pelvic floor services provided will not be billed to my insurance. Creekside Performance Center will not be submitting any insurance claims on my behalf. Payment is expected at time of service.

Patient Initials: _____

NOTICE OF PRIVACY POLICIES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

Uses and Disclosures

Here are some examples of how we might have to use or disclose your health care information:

- Your provider or a staff member may have to disclose your health information including all of your clinical records to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health care condition.
- Your provider and members of the staff may need to use your health information, examination and

treatment records and your billing records for quality control purposes or for other administrative purposes to efficiently and effectively run his/her practice.

You have the right to refuse to give us authorization to contact you to provide appointment reminders, information about treatment alternatives, or other health related information. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

For more details on HIPAA Privacy Policies and Procedures, copies are available upon request from the front desk.

Appointment Reminders and Health Care Information Authorization

Your provider and members of the practice staff may need to use your name, address, phone number and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not available, a message will be left on your answering machine or with the person who answers the phone. By signing this form, you are giving us authorization to contact you with these reminders and information and to leave messages on your answering machine or with the individuals at your home and/or place of employment.

Marketing Authorization

From time to time our practice would like to make you aware of products or services that you may have an interest in purchasing. This marketing would most likely occur in a newsletter that our office sends with the monthly statements. Your provider and members of the practice staff may need to use your health information, including your name, address, phone #, and your clinical records for the purpose of marketing products and services from Creekside Performance Center to you. Our office also utilizes website & social media platforms. I consent to the use of my photos with verbal permission on all platforms.

CONSENT FOR VIDEO RECORDING (IF INDICATED)

Purpose: Posture & Movement Assessment / Analysis and Progress Tracking

I understand that video recordings may be used during my care for the following purposes:

- Assessing posture, movement patterns, and functional performance
- Assisting in the clinical evaluation and treatment planning process
- Tracking changes and progress over time
- Enhancing communication of findings and recommendations

Confidentiality & Privacy

- All recordings will be kept confidential and treated as part of my medical/therapy record.
- Videos will not be shared outside of the clinic without my explicit written consent.
- Recordings will be stored securely in compliance with applicable privacy and healthcare regulations.

Consent & Acknowledgment

I acknowledge and consent to the video recording of my posture and movement for the purposes described above. I understand that I may withdraw this consent at any time by providing written notice to Live Zena/Creekside Performance Center.

By signing below, I acknowledge that I have read and understand the above stated information. Any questions have been answered satisfactorily, and I agree to the above stated policies. I acknowledge that I may request a copy of The Notice of Privacy Practices for Protected Health Information from the front desk and I understand the authorizations listed above.

Patient Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____