Integrative Health Inc
Experts Providing Healthcare

# Pelvic Floor Questionnaire and Consents

5191 S. Yosemite St., Suite B, Greenwood Village, CO 80111

**This questionnaire is in addition to the initial intake form (which must have been completed within the last two years).**

## Patient Contact Information

Name: _____ Date: _____

DOB _____ Age: ____ ☐ Male ☐ Female If minor, name of parent: _____

Cell #(_____)_____

Complete the information below if it has changed since completing the initial intake form:

Address:_____City:_____ State:_____ Zip:_____

E-mail address: _____

Employer: _____ Occupation:_____

Married or have a life partner ○ Yes ○ No Significant other's name: _____

Emergency Contact: _____ Relationship: _____ Phone:_____

2nd Contact: _____ Relationship: _____ Phone:_____

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If you are receiving a pelvic floor/bowl assessment, this assessment includes an internal vaginal exam to assess pelvic musculature health. Subsequent visits for treatment of findings may include internal vaginal massage, instruction in pelvic muscle and breathing exercises, rectal assessment, massage and other techniques as needed.

1. Date of last pelvic exam/PAP: _____
   a. Results?_____ Any past positive PAP?_____
2. Please list any pelvic or abdominal surgeries:_____
3. Please list types of birth control and length of time utilized:_____

If you have now, or have had in the past, any of the following, please check and explain with dates:

- ☐ Low Back Pain: _____
- ☐ Pelvic/Abdominal Pain:_____
- ☐ Menstrual Pain/PMS:_____
- ☐ Prolonged Bleeding/Altered Cycles:_____
- ☐ Pain During Sex:_____
- ☐ Sexually Transmitted Disease:_____
- ☐ Fibroids/Cysts:_____
- ☐ UTI/Bladder Infections:_____
- ☐ Hemorrhoids:_____
- ☐ Constipation/Irritable Bowel:_____
- ☐ Tearing with Birth:_____
- ☐ Childbirth Complications:_____
- ☐ Sexual Abuse:_____
- ☐ Physical or Other Abuse:_____
- ☐ Depression:_____
- ☐ Cancer:_____
- ☐ Drug Abuse:_____
- ☐ Smoking Habit:_____
- ☐ Eating Disorder:_____
- ☐ Other Relevant Info:_____

I understand and consent to these services being provided at the discretion of the provider. Patients may experience adverse events resulting from treatment, such as physical effects including soreness or bleeding, as well as emotional responses to the treatment. I understand and agree that if at any time I experience adverse events such as those described above, I will promptly consult my treatment provider (primary care physician or counselor, as applicable.)

Print Name:_____

Signature:_____ Date: _____