Pelvic Floor Physiotherapy Intake Form DATE _____________

Patient Information

Name _________________________________ Primary phone ____________________

Date Of Birth _________________________________ Alternate phone __________________

Address _________________________________ Postal Code _____________________

City _________________________________ Email _____________________________

AHC# _________________________________ Occupation _____________________

Family Doctor _________________________________

Emergency Contact Name/ Phone # ____________________________ Relation__________

How did you find us?_____________________________

Please describe your primary complaints and what you are hoping to achieve from pelvic floor physiotherapy:

1.____

2.____

When did it start? ____

What do you think caused the issue? ____

What seems to aggravate the problem? ____

Medical History

Abdominal Surgery (date) ____

Pelvic Surgery (date) ____

Urinary Tract Infection (UTI): □yes □no Last UTI: _____________

Smoking: □yes □no Chronic Cough: □yes □no Neck Problem: □yes □no Back problems: □yes □no

Height: ________ Weight: _______

Current Medications: ____

Allergies: ____

When was your last physical? ___________________ Findings? __________________________

Genealogical and Sexual History (Women):

Pregnancies: _____ # Births: ____ # Vaginal delivery: ____ # C-sections delivery: ____

Wt of heaviest baby: ___ lbs ___ oz Length of pushing: _______ Date of last delivery: _______

Forceps? □yes □no Tears? □yes □no Episiotomy? □yes □no HRT? □yes □no

Last Pap: _______________ Normal? □yes □no Birth Control Method: _______________

Sexually active? □yes □no Difficulty achieving orgasm: □yes □no

Pain with sex? □yes □no Penetration? □ Thrusting? □ Post-orgasm? □ Other: ________

Have you every had a bad experience with sex? (forceful, non-consensual, inappropriate or unwelcomed touching) □yes □no Please describe to your level of comfort:_______________
____
____
____

Health and Lifestyle Information

Have you ever suffered or do you currently suffer from the following conditions?

☐ Digestive problems
☐ Headaches/migraines
☐ Insomnia
☐ Arthritis
☐ HIV/AIDS
☐ Neurological (i.e. Stroke, Seizures, Epilepsy)
☐ Diabetes
☐ Multiple Sclerosis
☐ Bladder incontinence
☐ Anxiety or Depression
☐ Orthopedic problems (including fractures and arthritis)
☐ Cardiac problems (High blood pressure, heart disease/pacemaker)
☐ Unexplained weight loss/gain.
☐ TMJ
☐ Stomach ulcers
☐ Arm/leg pain
☐ Other (please explain below)

☐ Major traumas(accidents, falls)
☐ Osteoporosis
☐ Inflammatory illness
☐ Anemia/blood disorders
☐ Major infection
☐ Fainting/dizziness
☐ Parkinson’s disease
☐ Respiratory problems
☐ Cancer
☐ Thyroid Problems
☐ Pain in stomach/chest
☐ Skin conditions
☐ Lower back pain
☐ Currently pregnant

List any details for any checked above:

____
____
____
____

Please describe your present symptoms as best you can:

____
____
____
____

Does this Condition interfere with your daily life? (If yes, please explain)

____
____

Physiotherapy Consent Form

Informed Consent: I understand the terms and conditions associated with my assessment and treatment for Physiotherapy as explained to me and do voluntarily give my consent to the assessment and treatment. I have received information about the proposed physiotherapy and rehabilitation services, alternative courses of action, the benefits, risks and side effects of the services and the consequences of not having the service not proposed. I wish to rely on the clinician to exercise judgement during the course of the procedure that he/she feels at the time, based upon the facts he/she then knows is in my best interest. My clinician has responded to all my requests for other information about the services proposed.

Associated Risks: I have been informed of the potential risks associated with physiotherapy treatment. They include, but are not limited to burns from modalities, redness, increase discomfort, re-injury, muscle sprains and strains and fractured bones. I understand that I may have increased soreness following treatments and will inform the therapist immediately of any concerns. I understand that the program has been designed and will be continued to be monitored by a physiotherapist. I consent to the treatment to be completed by a Registered Physiotherapist.

Release of Information: I give my consent for the employees of the physiotherapy office to obtain or release information from/to physicians, lawyers, family members, insurance companies, case managers, hospitals, or health care practitioners as deemed necessary for my continuing care of the processing of my claim. I also release the employees of the clinic from any, and all claims directly associated with the release of this information. I give permission for the physiotherapy office to reach me at my primary/alternative number and to leave a message when required.

I understand that the program has been designed and will be continued to be monitored by a physiotherapist. I consent to the treatment to be completed by a Registered Physiotherapist.

Cancellation policy

We are here to provide you with the very best care and attention. Your treatment time is reserved just for you. In our commitment to provide an outstanding experience to all of our patients and out of consideration for our physiotherapist's time, we will be enforcing a cancellation and no-show policy. **A minimum of 24 hours is required for cancellations or 50% of the service fee will be charged to your account.** As a courtesy to our patients, if you arrive late, your appointment will be shortened to the remainder of your original scheduled appointment. By signing below, you acknowledge that you have read and understand our policies. Thank you for your understanding. We look forward to helping you remain healthy, strong and empowered.

Patient/ Legal Representative Signature: ____

Name: ____Dated: ______________________

Physiotherapist: _______________________________ Dated: ______________________